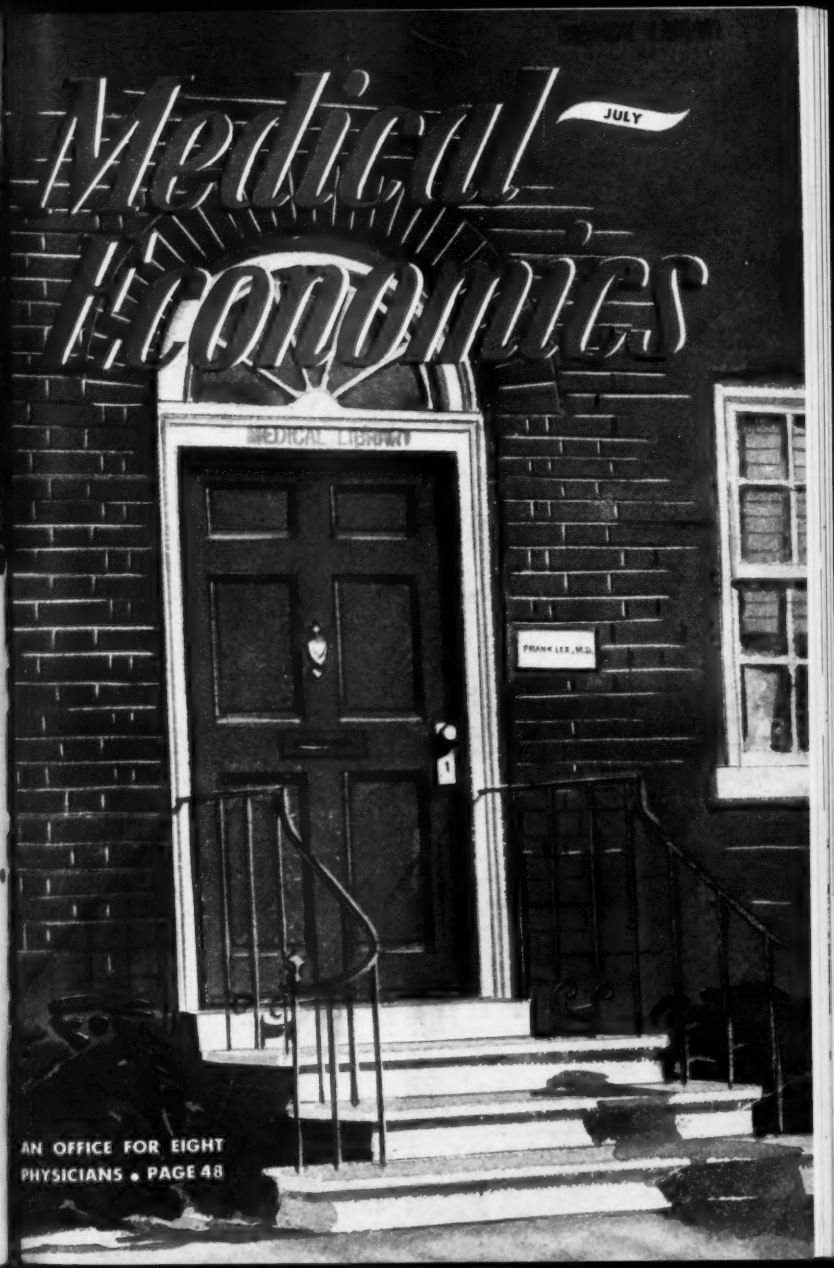
Medical Economics

JULY



AN OFFICE FOR EIGHT PHYSICIANS • PAGE 48

Leaf of Life . . .

THE ORAL ACTIVITY OF DIGITALIS LEAF **is primarily due to digitoxin, the active principle of Purodigin. Digitoxin is "first in the choice of digitalis materials for therapeutic use."**—Gold et al., J. Pharmacol. 82:187, 1944

SMALL DOSAGE • WELL TOLERATED • LOW COST

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DIGITOXIN

Wyeth

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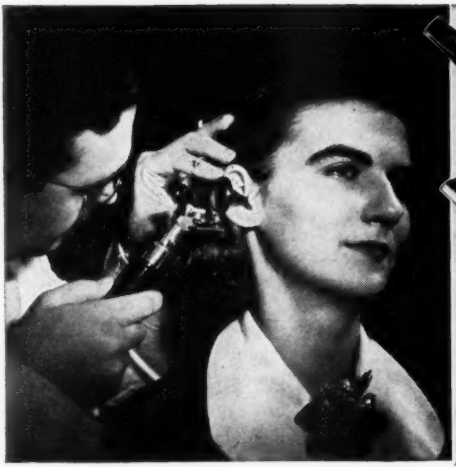

Widest Field

FOR EXAMINATION OR OPERATION

Swivel-head construction gives the Bausch & Lomb Arc-Vue Otoscope an obstruction-free operative field 36% wider than previous models. As speculum mount swings left or right, orifice is always at center of brilliant illumination field and at sharp focus with respect to the rotatable 2½x magnifying lens. "Most convenient otoscope I ever used," say hundreds of doctors.

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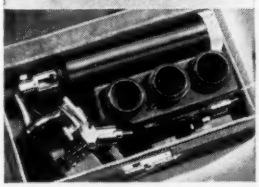
BAUSCH & LOMB

Arc-Vue

OTOSCOPE

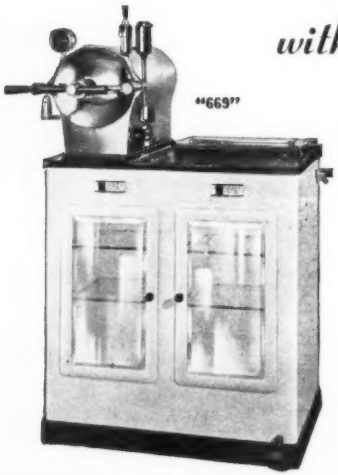
Brilliant true-color illumination... lightweight ...sharp focus... Plastic specula, thin, light, strong, easily sterilized, reflection-free, attached or removed with a half-turn... Tongue depressor is directly under speculum mount.

(Below) Medical Set No. 1. Arc-Vue Otoscope and improved May Ophthalmoscope in sturdy professional pocket case.



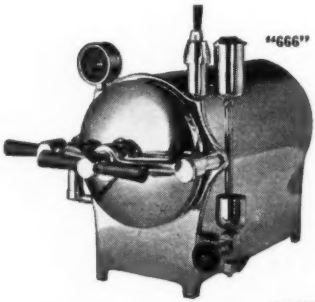
Give patients unequaled protection

with Castle Sterilizers



"669"

WHICHEVER Castle Sterilizer you select you can be sure that your patients will get the last word in scientific sterilizing protection. Each is designed for beauty as well as use.



"666"

The "669" Castle Instrument Sterilizer and Autoclave—the favorite of doctors with an expanded practice who want a sterilizer to meet their every need.

The "666" Castle Autoclave provides complete hospital sterilizing safety, destroying spores as well as bacteria. It occupies little space, can be set on a table or supplied with a stand (666-S).

The "673" Castle Instrument Sterilizer—the ideal general purpose 16″ Instrument sterilizer and storage cabinet. Accommodates Autoclave by change of top if desired later on.

This is the time to secure equipment that will help you most with your present practice and your future plans. Write for complete details.

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Columbus, Ohio

Medical Economics

THE BUSINESS MAGAZINE OF THE MEDICAL PROFESSION

JULY 1946

Cover design by Tom Roots

CIRCULATION 127,000

H. Sheridan Baketel, A.M., M.D., Editor-in-Chief. William Alan Richardson, Editor. Ross C. McCluskey, Managing Editor. Lansing Chapman, Publisher. W. L. Chapman, Jr., Business Manager. R. M. Smith, Sales Manager.

25c a copy; $2 a year (Canada and Foreign, $2.50 a year).

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B-D ACE ADHESIVE No. 10

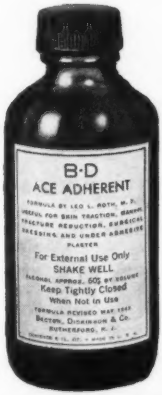
ELASTIC and ADHESIVE

An improved, tested bandage that has demonstrated its value for the treatment of varicose veins and ulcers, for strapping, support, minor cuts and abrasions

Improved B-D Ace Adhesive has long shelf-life. It withstands the standard one-week baking test without impairment to adhesive or other qualities.

Made of carefully selected ingredients, skin reactions are minimized. The adhesive coating will not pull off the bandage.

The backing of all-cotton Ace Elastic Bandage permits comfortable movement, yet provides firm support.



ACE ADHERENT

An antiseptic, resinous liquid compound of adherent qualities. Originally devised for skin traction, it is now widely used for many other purposes. Useful for improving the tenacity of adhesive tapes on the skin, for holding dry bandages in place, for traction, and on the hands as an aid to manipulation. Available in 4 oz. bottles, through your regular dealer.

A sample of Ace Adherent will be mailed on request.

B-D PRODUCTS
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RELIEF IN NEURITIS

In treatment of sciatic, peripheral and other forms of neuritis, the value of mild counterirritation, as provided in MINIT-RUB, has long been established.

Shortly after application, MINIT-RUB—counterirritant, analgesic, decongestant — acts beneath the skin surface to improve local circulation by direct rubefaction. At the same time, by reflex action, MINIT-RUB helps speed comforting warmth and relief to aching muscles and nerves.

To ease "between visit" pain in neuritis — which often impedes success in treating the condition itself —daily home-massage with MINIT-RUB is suggested. This helps the patient and increases effectiveness of office treatments.

RECOMMEND SUPPLEMENTARY HOME-MASSAGE WITH MINIT-RUB TO YOUR NEURITIS PATIENTS

MINIT-RUB IS ALSO EFFECTIVE IN SIMPLE NEURALGIAS

MINIT-RUB

THE MODERN RUB-IN

STAINLESS • GREASELESS • VANISHING

A Product of Bristol-Myers Company, 19ME W. 50th St., New York 20, N.Y.

Spinach, as everybody knows, grows best in soft, rich soil. Usually, there is a fine dusting of grit hidden in the nooks and crannies of the leaves which must be removed before preparing spinach for Gerber's Baby Foods.

Our laboratory technicians found a loss in the mineral content when checking the newly washed spinach against the same spinach fresh from the fields. The loss was finally tracked down to the five or six washings we thought necessary to remove the grit.

From then on, a new technique was adopted which *shook* the leaves clean and required but *two washings*, with a consequent gain in mineral content.

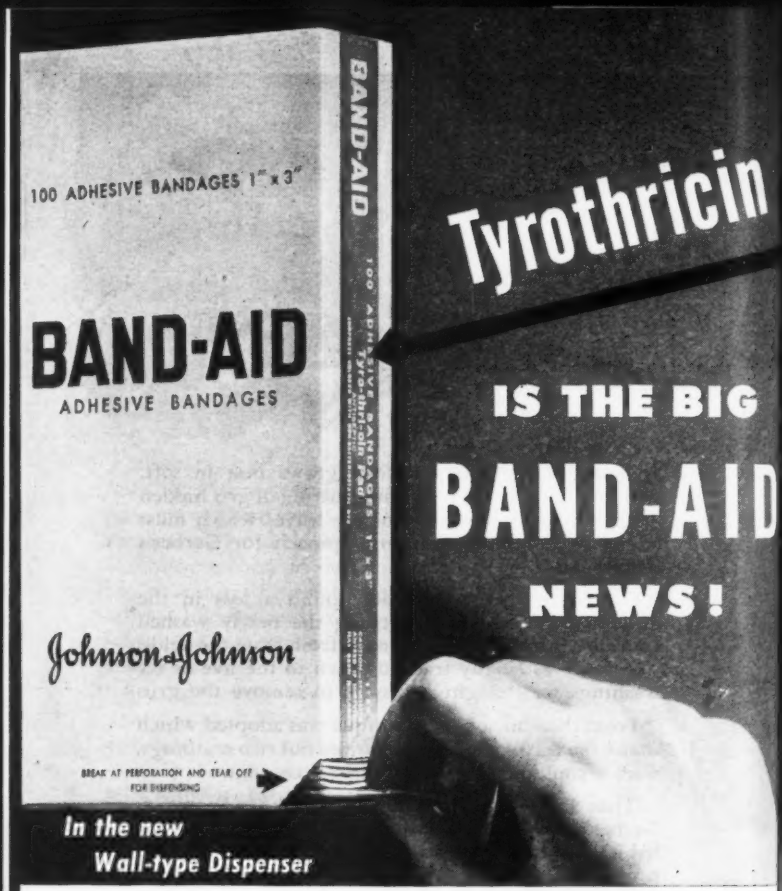
That kind of care is typical of the way we at Gerber's take our responsibility of feeding America's babies. Working hand-in-hand with the medical profession, we agree that "Babies are the most important people!"

Write for free samples of Gerber's Cereal Food and Gerber's Strained Oatmeal, address Gerber's, Dept. 227-6, Fremont, Mich.

Gerber's Baby Foods

FREMONT, MICH.—OAKLAND, CAL.

CEREALS • STRAINED FOODS • CHOPPED FOODS



• Tyrothricin, the amazingly effective topical antibiotic, is now incorporated in this *newest* Band-Aid Adhesive Bandage.

What's more, this compact, sterile adhesive compress is *now available* in the professional box which also serves as a handy wall dispenser. Just open at end and 100 adhesive bandages (1"x 3") are at your fingertips. Saves time—saves waste—gives extra protection.

ORDER FROM YOUR DEALER

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NEW BRUNSWICK, N. J. CHICAGO, ILL.

*BAND-AID is the Reg. Trade-mark of the adhesive bandage made exclusively by Johnson & Johnson.

Panorama

▶ Kennedy General Hospital, Army institution at Memphis, is slated to become the Veterans Administration's first teaching facility . . . Rumania's Health Ministry now operates one of the country's principal gambling spots, the Sinaia Casino . . . Favoring passage of the W-M-D bill, Dr. G. C. McKinney of Lake Charles, La., has written to the Murray committee objecting to allegedly unfair reports of the hearings in the Journal A.M.A. . . . Blinded in one eye forty-two years ago when a chip of wood struck him while he was wielding an axe, Pete Bird, Railway Express agent at Shelbyville, Miss., is reported to have regained full use of the optic—when another chip of wood struck him recently in the same eye and tore loose a cataract.

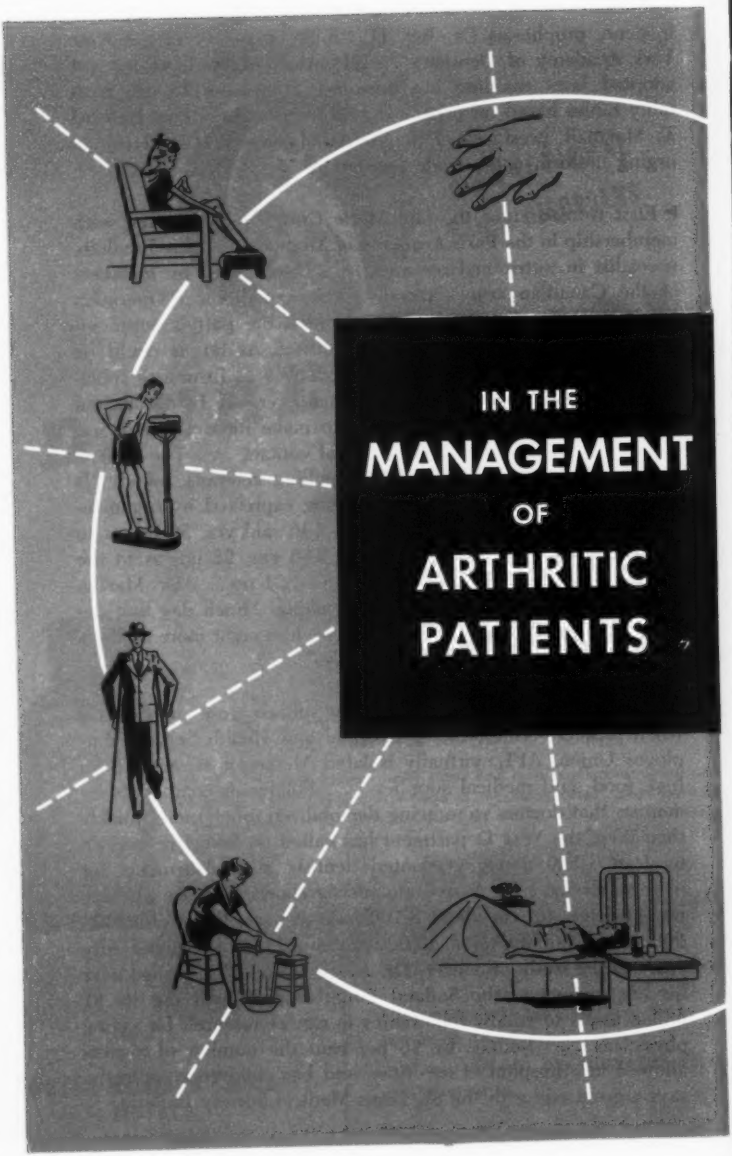
▶ The present system of compulsory health education used in high schools of New York State will inevitably result in "a nation of fearful symptom-hunters and hypochondriacs," a Christian Science committee charged recently in requesting the state Board of Regents to halt such instruction. Denying the request, the board also refused to excuse C.S. pupils from the obligation of taking the courses . . . The new third edition of the Directory of Medical Specialists will not be ready for distribution before early autumn, says its publisher, the A. N. Marquis Co., Chicago . . . Unable to find a car for sale, Dr. Eugene A. Fierro, New York City medical veteran, is making his calls in the only vehicle he could get: a walkie-talkie-equipped Army reconnaissance truck.

▶ Alleging that private insurance companies have financed propaganda against the W-M-D bill, George F. Addes of the CIO's United Auto Workers has asked for a Congressional inquiry . . . Detroit obituary columns recently listed the death of Dr. Fred M. Meader, the bacteriologist who played such a prominent part, some thirty years ago, in solving Manhattan's famed "Typhoid Mary" case . . . Atomic energy—by making metals in the mouth radio-active—may yet play its part in oral

hygiene, prophesies Dr. Roy D. Ribble, secretary of the New York Academy of Dentistry . . . Fourteen states have not yet adopted laws enabling life insurance companies to use mortality tables based on present-day life expectancy, says Edward K. Marshall, president of the Actuarial Society of America, in urging uniform nation-wide legislation.

▶ First woman since the late Marie Curie to be honored with membership in the Paris Academy of Medicine is Lucie Randoin, specialist in nutritional research . . . Unobserved by members of the Canadian army's recent Arctic expedition ("Operation Musk Ox"), an Eskimo husky consumed the party's entire vitamin supply—30,000 pills—at one sitting. As far as could be determined, the dog suffered no ill effects . . . Insurance solicitors, finding doctors harder to see than ever, are being advised by the Accident & Health Review to make more effective use of the telephone as the best means of contact . . . The Wayne County (Detroit) Medical Society, polling veterans, asked: "Is your medical-economic viewpoint being expressed by organizations representing you?" As to AMA, 146 said yes, 56 no; as to the Michigan State Medical Society, 186 yes, 22 no; as to the Wayne County Medical Society, 201 yes, 21 no . . . Dr. Martha M. Eliot of the Children's Bureau speaking: "Each day that debate [over the W-M-D bill] goes on, we lose eight more mothers and eighty-five more babies needlessly."

▶ Residents of Elmhurst, a Chicago suburb, rose up in arms when pickets of the striking Hospital and Health Service Employes Union, AFL, virtually isolated Memorial Hospital from fuel, food, and medical supplies . . . Following complaints by dentists that doctors were being demobilized much more quickly than they, the War Department has called on Selective Service to draft 1,500 newly graduated dentists as replacements for men in service . . . A six-state survey shows that the average person drives his car about 8,100 miles a year; the doctor, 13,000 miles; the salesman 19,000 miles . . . After giving fifty years to the study of cancer, Dr. Albert Soiland has turned over his life savings to the Soiland Foundation; it will use its $1 millon assets to endow fellowships in cancer research for young physicians . . . Reduce by 75 per cent the number of visitors allowed in a hospital at one time, and bar children completely, says a guest editor of the St. Louis Medical Society Bulletin.


IN THE
MANAGEMENT
OF
ARTHRITIC
PATIENTS

"Time Clock" DYSPEPSIAS

Hastily consumed meals, factory whistles, and the insistent challenge of the time clock — such is the background of functional digestive disturbances among many office and factory workers.

Subjective relief of "time-clock" dyspepsias is frequently affected by the administration of Peptenzyme Digestant Tablets which contain proteolytic and amylolytic enzymes in palatable form. The convenience of the tablets, which may be slipped into the pocket, commends itself to both physician and patient.

Each Tablet contains: Pepsin N. F. 65 mg., Pancreas desiccated 32 mg., Duodenum desiccated 13 mg.

Dosage: 2 to 8 tablets with each meal and at bedtime.

Available: Bottles of 25, 100, 500 and 1000.

REED & CARNRICK

PEPTENZYME DIGESTANT TABLETS

Unexcelled *Seeing!*

THE BURTON FRESNEL
3 in 1 Medical Light

NOW INCORPORATING THE HIGH QUALITIES AND STANDARDS OF PEACETIME PRODUCTION

Never before a light like this! Never before advantages like these offered physicians by the versatile BURTON Fresnel Medical Light.

Lowest-priced all-purpose light on the market.

3 great lights in 1—triple illumination for diagnostic, operative and examination work.

Over 1000 foot-candles of heat-free, color-corrected true 'white' light for your office.

Easy finger-tip control to adjust angles, vary light fields or light intensity.

Beautiful bakelite construction; impressive modern design.

Standard 100-wt. bulb; no transformers or rheostats required; operates from any 110-volt line.

The BURTON Fresnel 3 in 1 Medical Light is available now through your dealer. Write today for full information.

No. 1200A — Desk Model & Microscope Lamp
Dark and bright field; monocular or binocular. Lighting head detachable for easy mounting on floor stand. Filters available. Price, Complete $13.75

No. 1204A—Gooseneck Model
12 in. of heavy-duty black-crackle, flexible "gooseneck." Adjustable from 42½ to 64 in. Price, Complete $21.75

AVAILABLE IN 3 MODELS

No. 1201A—Floorstand Model
Adjustable. 41½ to 64½ in. Black crackle finish, polish trim. Balanced base. Lighting head tips to any angle. Price, Complete $19.75

No. 1202A—Wall Model
(Not illustrated) Attractive telescoping bracket extends to 25½ in. Takes little space when not in use. Price, Complete $21.75

No. 1201A-S—("Shortie") Floorstand Model
(Not illustrated) Same as No. 1201A Floorstand Model excepting height. Adjustable from 30½ to 52 in. Price, Complete $19.75

AS A SPOTLIGHT

AS A FLOODLIGHT

FOR DIFFUSED LIGHT

BURTON
SCIENTIFIC INSTRUMENTS — PROFESSIONAL EQUIPMENT

BURTON
MANUFACTURING COMPANY
3855 N. Lincoln Avenue, Chicago 13, Ill.

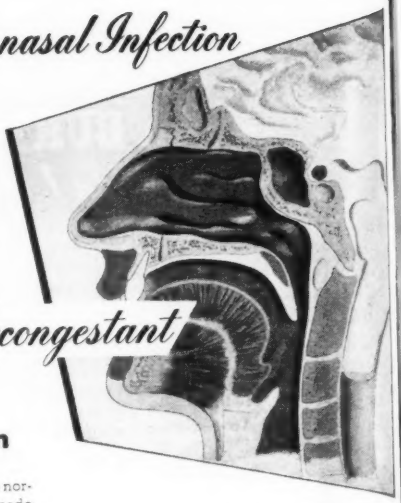
In treating Para-nasal Infection

support nature's own first line of defense . . . with

ARGYROL

Bacteriostatic Decongestant

without rebound action



Your main purpose, of course, is to restore normal function in the nasal passages. This is made doubly difficult with the use of vasoconstrictors whose action is frequently followed by compensatory congestion thus creating a vicious circle.

Avoid that vicious circle . . . with ARGYROL

ARGYROL is the natural, the obvious choice of the discriminating practitioner, because the cleansing, demulcent and bacteriostatic actions of ARGYROL *aid the natural defense mechanism* without disturbing the normal physiology of the mucous membranes.

Three-Fold Action of ARGYROL:

1. ARGYROL is decongestive, without irritation to the membrane, and without ciliary injury.
2. ARGYROL is powerfully bacteriostatic, yet is non-toxic to tissue.
3. ARGYROL stimulates secretion and cleanses, thereby enhancing Nature's own first line of defense.

Three-Fold Approach to Para-nasal Therapy:

1. The nasal meatus . . . by 20 per cent ARGYROL instillations through the nasolacrimal duct.
2. The nasal passages . . . with 10 per cent ARGYROL solution in drops.
3. The nasal cavities . . . with 10 per cent ARGYROL by nasal tamponage.

ARGYROL *the Physiologic Anti-infective with broad, sustained action*

Made only by the **A. C. BARNES COMPANY, NEW BRUNSWICK, N. J.**

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Speaking Frankly

Municipal Jobs

What many a young physician-veteran needs, more than anything else, is a chance to earn some money until he gets a toehold on private practice. I suggest that county medical societies compile lists of physicians who want part-time employment and then persuade municipal authorities to appoint them to salaried posts for a period of from three to five months, on a rotating basis.

M.D., New Jersey

Veterans can look for little assistance in this direction. Most health department jobs are on a civil service basis and involve permanent tenure. Heads of health departments in twenty cities, questioned by MEDICAL ECONOMICS, *found the proposal impracticable. Said one: "We're overloaded with veterans who have returned to their jobs." Another: "It takes at least five months to train a man." A third: "It would disrupt the efficiency of the department and be unfair to competent, trained, and experienced physicians who are not veterans."*

Red Tape

One of the minor but annoying problems facing demobilized medical officers is that of getting their narcotic permits reinstated. The narcotics bureau has established a policy of requiring all demobilized men to submit to re-examination. One doctor I know spent three weeks tied up in rigamarole and red tape. First, he asked if he could have his old number back; the bureau said it could not promise that and then took three weeks to handle the case. Meanwhile, of course, my friend could not get his prescription blanks printed.

Finally, he said he couldn't wait any longer and asked if he might file for a new number. The bureau replied that such action would constitute an attempt to defraud the Government (the law says you can't allow the original permit to lapse, and a fine is involved).

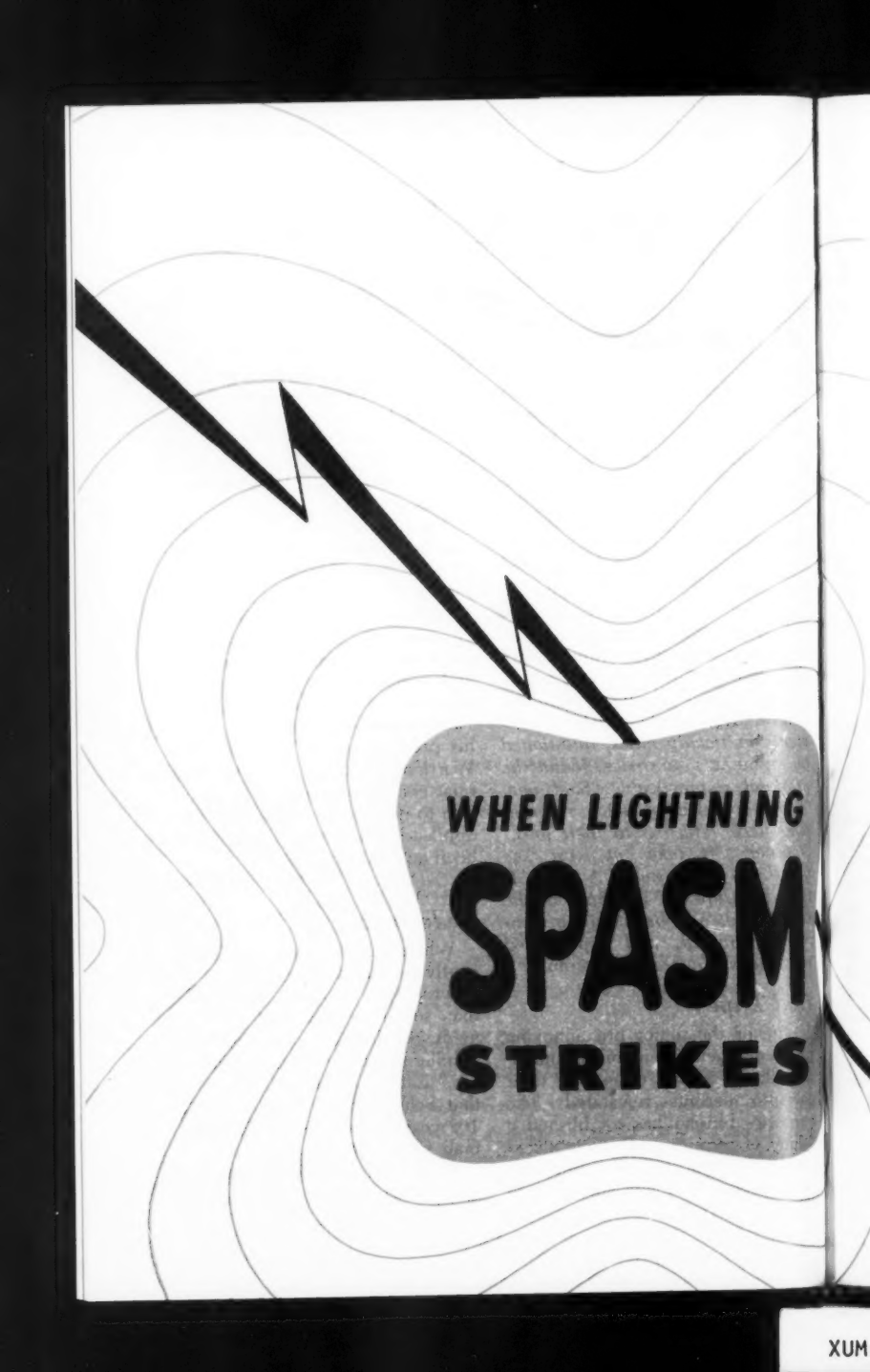
Actually, this doctor practiced (and wrote prescriptions) before his pre-war permit was reinstated. Worried, he called narcotic headquarters and wangled oral permission to use his old number until his application for reinstatement had been acted upon.

M.D., Maryland

Pedestrian

Which Schiller "took a walk"? Recently, in MEDICAL ECONOMICS, Dr. Lewis J. Morrman said: "Under German social security, the quality of medicine declined and costs rose. Schiller had the courage to walk out . . ." Later, Dr. H. S. Unger wrote that Schiller walked out in 1782—102 years before the advent of German social security.

Well, if Dr. Morrman had in mind Dr. Walter Schiller, the renowned


WHEN LIGHTNING
SPASM
STRIKES

FOR EFFECTIVE SPASMOLYSIS of smooth muscle fibers, the natural belladonna alkaloids, synergistically enhanced with the sedative and antispasmodic action of phenobarbital, are recommended by many pharmacologists as the **smoothest, most efficient, least toxic** therapy.

The width of clinical application of Donnatal is based on the synergistic, yet selective action of the three alkaloids on secretory glands and a broad range of smooth muscles... **plus** the coupling and potentiation of their action with phenobarbital, the most generally useful of the barbiturates. With only 1/4 gr. of this sedative per tablet, Donnatal may be prescribed for extended use without fear of untoward reaction. Other advantages are its stability and economical price.

Indications: Smooth muscle spasm wherever manifested, as in g-i tract, g-u tract, respiratory and cardiovascular systems.

AVAILABLE: In packages of 100 tablets.

FORMULA: Each tablet contains belladonna alkaloids (hyoscyamine, atropine and hyoscine) equivalent to about 5 min. tr. belladonna, plus 1/4 gr. phenobarbital.

DOSAGE: 1 to 2 tablets daily. In certain cases, as high as 9 tablets may be given within 24 hours without fear of untoward reaction.

A. H. ROBINS COMPANY, RICHMOND 19, VA.

DONNATAL *a Robins' Triumph*

Viennese pathologist who is now practicing in Chicago, he is right: Schiller did walk out. And if Dr. Unger is referring to Johann Cristopher Frederick Schiller, poet and author, *he* is right too, for Johann left the Reich and produced much literature in other parts of the world.

Nora D. Dean, M.D.
Worcester, Mass.

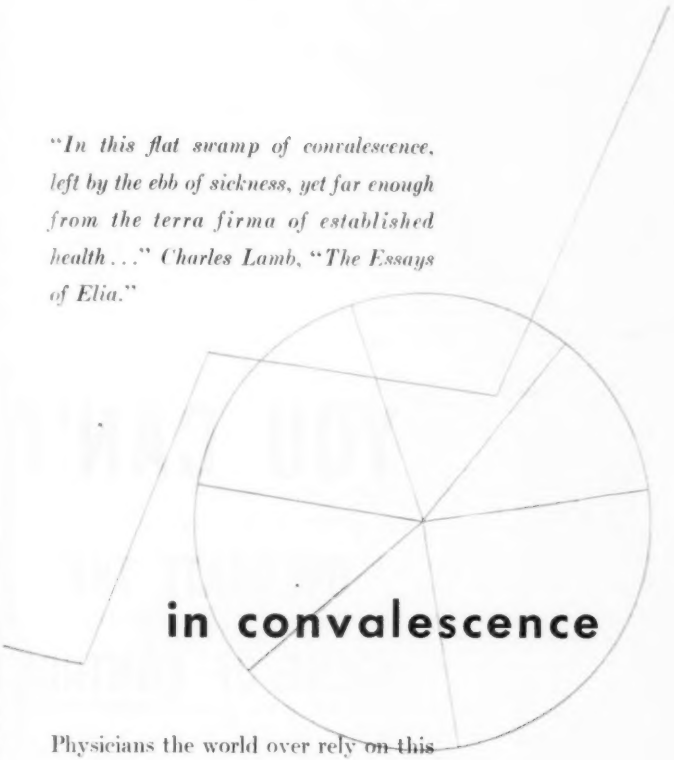
No Vacation

It is a curious fact that people have no reluctance to call upon a vacationing physician for all sorts of emergency services—and an even more curious one that some of them think they are doing the M.D. a favor by preventing him from becoming rusty! There is rarely any proffer of a fee; indeed, the physician is lucky if he is thanked for his efforts. No wonder, then, that many a doctor drops his title when he goes off on a vacation and travels as plain "Mr."

When I went aboard a cruise steamer several years ago the purser greeted me with these words: "We are glad to have a doctor along! You never can tell when you may need one." Early next morning I was routed out of bed to minister to a fellow-passenger who was vomiting violently after overindulgence in alcohol. A few days later, a member of the crew broke his thumb. Again I was called upon to give medical service—and received not even a thank you from the patient or the ship's officers.

A surgeon whom I know has a cottage on a Canadian island. For several summers he enjoyed his vacations there. Then natives from a wide area—especially Indians—began coming to him for free medical advice. They called him in for

"In this flat swamp of convalescence, left by the ebb of sickness, yet far enough from the terra firma of established health . . ." Charles Lamb, "The Essays of Elia."



in convalescence

Physicians the world over rely on this easily tolerated, outstandingly palatable tonic to restore appetite, vigor and general tone . . .

Eskay's Neuro Phosphates

clinically proved and universally accepted

Smith, Kline & French Laboratories
Philadelphia, Pa.

YOU CAN'T

OVERRATE THE VALUE OF CONTROL

UNITED-REXALL DRUG CO.

births, and there were more and more of them each summer, the natives apparently planning it that way. Finally, my friend (who is not an obstetrician and not a Dr. Grenfell) gave up going to his island. "I can work and get paid for it in the city," he concluded.

Shall the physician vacation incognito? His conscience must be his guide. If he does, he will save himself a lot of annoyance from the psychoneurotics and bores invariably present in any group of travelers. After all, a lawyer does not spend his spare time giving free legal advice. Even a clergyman is not imposed upon. Why should a doctor be?

M.D., Ohio

Orchid

I have been watching your wonderful work in publishing, without charge, position-wanted ads for physician-veterans. Keep it up!

Paul P. Hochberg, M.D.
Monmouth, Ill.

Solid Front

I have protested to the AMA about its infantile work in opposing the Wagner-Murray-Dingell bill. I suggest that if it is interested in the welfare of the doctor, it obtain the signed pledges of 100,000 licensed physicians that they will absolutely refrain from joining in any socialistic medical scheme.

Everett R. Brown, M.D.
Chicago, Ill.

Proprietaries

For years, medical oracles have been lamenting that doctors have forgotten how to write prescriptions, that they are learning materia medica from detail men, that they

"I'm going to grow a hundred years old!"

...and possibly she may—for the amazing strides of medical science have added years to life expectancy

● It's a fact—a warm, wonderful fact—that this five-year-old child, or your own child, has a life expectancy almost a whole decade longer than was her mother's. Not only the expectation of a longer life, but of a life by far healthier. Thank medical science for that. Thank your doctor and thousands like him ... toiling ceaselessly ... that you may enjoy a better life.

According to a recent independent nationwide survey:

More Doctors Smoke Camels

than any other cigarette

R. J. Reynolds Tobacco Co., Winston-Salem, N. C.

prescribe proprietaries to the exclu sion of the good old galenicals.

The usual objections to proprie taries are that (1) they cost to much, (2) their dosage and purit standards are uncertain, (3) the rob the pharmacist of opportunitie for research, (4) the prescription too easily read by the patient, (5 they spare the M.D. the disciplin of calculating his own dosage an formulations.

It seems to me that all five objec tions are faulty.

1. Some named combinations d cost more than the same prescrip tion with a non-proprietary name But many do not. I suppose a name luminal is somewhat more expen sive than an anonymous phenoba bital. But I am sure that if I ordere the druggist to get the necessar raw materials to make up, say amphetamin, he would have t charge more than for a named be zedrine.

When you call for a fluid extrac the druggist is supposed to set u his own apparatus and do the e tracting himself. If you call for proprietary fluid extract, he ju pours it out of a big bottle into a li tle one. It is obvious that the latte is going to retail for less than th former.

2. Dosage and purity standard of reputable proprietaries are ofte more—not less—exact than those o prescriptions made by retail drug gists whose skill varies and whos stock is not uniformly fresh.

3. The large drug houses engag in much more extensive and muc more precise pharmaceutical re search than an individual pharma cist ever finds possible.

4. It is true that proprietary pr scriptions are more easily read b

SEAMLESS

Pro Pak Gauze

25 YARD PACKAGE

Convenient . . . Economical . . . Sterile

A prepared sterile gauze dressing in a continuous 25 yard length, that conserves space, time and money. It is clean white highly absorbent gauze at its best. Protected sterility and versatility have made Pro-Pak the choice of busy doctors everywhere. Order through your Surgical Supply Dealer.

- Adaptable 8 ply 4½" strip with folded-in selvage permits use of large or small cuts as needed.
- Practical reclosable carton sterilized after packing—dispenses exact quantities of gauze.
- Entire length is usable—unused portion remains protected by interleaving paper wrapper.
- 25 yard size in 28/24, 24/20, 20/16 mesh; also in 5 yard length 28/24 mesh.

SURGICAL DRESSINGS DIVISION

The **SEAMLESS** SR **RUBBER** *Company*

NEW HAVEN 3, CONN., U.S.A. REG. U.S. PAT. OFF. FINEST QUALITY SINCE 1877

patients; but if druggists and manufacturers cooperated, even this drawback could be eliminated. In many instances, the retail pharmacist could refuse to sell a proprietary to a person without a prescription and the manufacturer could refrain from advertising his product to the laity.

5. The M.D. has enough to do without filling his head with the mathematical details of how to compute the amount of salt to be placed in a three ounce bottle if he wants a 5 per cent solution to be given in drach dosage.

M.D., New Jersey

Fed Up

How long will we have a situation whereby teachers of clinical pathology are paid only a fraction of the income of those practicing the specialty? I, for one, have about decided that the advantages of teaching are not worth the penalties inflicted.

M.D., Arkansas

Correction

A most unfortunate typographical error in my article on osteopaths, in the May issue, completely distorted the meaning of one sentence. That sentence was written, "The comparatively few homeopaths practicing today are respected by physicians and laymen alike." But when it got into print it read: "Comparatively few homeopaths practicing today are respected by physicians and laymen alike." Needless to say, that doesn't represent my views at all!

F. Bruce Kimball, M.D.
Ann Arbor, Mich.

New bifocals for the proofreader and an apology to Author Kimball.

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the village church...the white picket fence ...the broad highways which lead to great cities . . . above all, the homes which breed good citizens.

AMERICA'S strength is bred in her homes. In thousands of towns and cities, where modest bungalow stands proudly alongside a local showplace, where the well-kept lawn of one merges with its neighbor . . . here, the roots of good citizenship are deeply planted.

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These two recent volumes provide important testimony as to the value of Castellani's Paint even under the frequently adverse conditions encountered in Military Medicine.

Rorer has overcome the one disadvantage of Castellani's Paint—instability—which has always limited its usefulness. Castellani's Paint "Rorer" is now available in stable form, ready for instant use, and suitable for dispensing or prescription purposes.

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Castellani's Paint

1. W. B. Saunders Company, Philadelphia, 1942
2. Ibid., 1945

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ERYTHROL TETRANITRATE MERCK in Angina Pectoris

It is generally agreed that the acute attack of anginal pain is most readily relieved by the prompt removal of the provocative factor, and by the use of nitrites. For this purpose, the rapidly acting nitrous and nitric acid esters, amyl nitrite and nitroglycerin, are considered most useful.

For prophylactic purposes—to control anticipated paroxysms—the *delayed but prolonged action* of erythrol tetranitrate is more effective. Erythrol tetranitrate, because of its slower *and more prolonged action*, is also considered preferable for the purpose of preventing nocturnal attacks.

The vasodilatation produced by Erythrol Tetranitrate Merck begins 15 to 20 minutes after administration, and lasts from 3 to 4 hours.

The properly timed administration of a vasodilator having a sustained effect may prevent the following episodes of angina pectoris:

- **The man who finds it necessary to stop and rest when he walks to the train in the morning.**
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- **The man who has pain in his chest and arms, and weakness upon any anxiety, anger, or nervous strain.**

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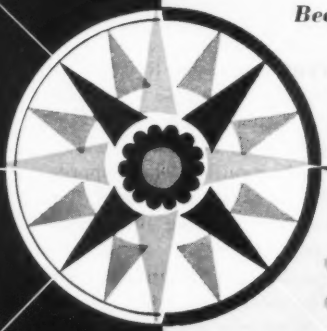
Woman requires

4 times as much iron

Guiding Principles in Estrogen Therapy



Because estrogens are usually required over prolonged periods, the preparation chosen should be:

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Sidelights

If you want to infuriate Albert Deutsch, columnist on New York's PM, call compulsory sickness insurance "socialized medicine" or "Government medicine"; or hint that it might result in "bureaucracy" or "regimentation." That is "unprincipled smear language," says Mr. Deutsch, and he hates smear language. So much so, that when he was attacking the National Physicians Committee in PM, he used these terms: "AMA-Drug Trust Axis Sponsors Campaign of Lies . . ."; "Peddle Propaganda Pills"; "a sordid tale of medical intrigue"; "big patent-medicine companies"; "unholy alliance"; "dastardly slur"; "opportunistic advertising geniuses"; and "tripe."

Now, Albert, run up to the bathroom and wash your hands.

"The green medicine seemed to help." It's nice to hear that from a patient, provided, of course, you happen to know which of your prescriptions produced a green liquid. Time was when the M.D. selected the vehicle for the Rx and knew pretty well what the finished product looked like. Today, the average senior medical student knows all about the pharmacology of tincture of digitalis, but he has never actually seen a bottle of it. Similarly with tablets. They vary in color, size, shape, and scoring. Unless the doctor has seen the tablet he is prescribing, he does not know, for instance, whether it is scored for breakage into half doses. And the doctor should know something of the taste, and even the odor, of the medication he is calling for. Trouble is, under present conditions, few M.D.'s really know what the finished Rx looks like, which may sometimes be embarrassing. That is why one Midwestern physician, stymied by a patient's request for "more of that pink, sirupy medicine you prescribed last month," decided to learn once and for all what the commoner medicines looked, smelled, and tasted like. He called on the neighborhood pharmacist and peered, sniffed, and tasted until he finally had a clear idea of the physical properties of medications, when previously all he had known was their pharmaceutic properties. "It was a well-spent afternoon," he admitted. "Now when I write a prescription, I do so with some additional confidence. I really know what I'm calling for."

The medical profession may soon be hearing a good deal of the newest CIO union—United Public Workers of America. The UPWA represents a merger of the United Federal Workers of America and the State, County, and Municipal

Workers' Union. Neither of these organizations ever strayed far from the Communist line, and there is no reason to believe that as the UPWA they will set a precedent.

What makes this of interest to the medical profession is that the SCMWU, now the UPWA, has been organizing nurses and other hospital workers. Recently it called an abortive strike at the big health center operated by the International Ladies Garment Workers' Union in New York City. This may have been an attempt to go after easy pickings, but some New York labor reporters say that it was a political strike aimed at embarrassing the ILGWU's president, David Dubinsky, who is well known as an avowed and tough-minded anti-communist.

Inter-union politics are scarcely a concern of doctors. But the political aims and methods of a union organizing hospital workers are quite another matter. It would be unfortunate for both the profession and the public if our hospitals were to come under the thumb of a union whose leaders use the membership as counters in a devious political game.

Two "bugs" have developed already in California's new sickness-benefit law, which doesn't go into effect until May 1947. The legislation, which provides that California workers shall receive regular unemployment benefits when they are absent from work through illness, has a certification form which worries physicians. The act says that "physicians and surgeons" must certify that workers are ill and cannot perform their usual occupa-

Season's Greetings

The sneezing, the itch, the tears, edema and obstructed breathing—all herald a new hay fever season driving patients to your office in search of relief.

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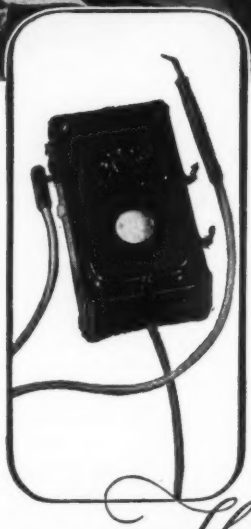
tions; then it says that "physicians and surgeons" shall be defined to include all those holding certificates issued by the Board of Medical Examiners, Board of Osteopathic Examiners, and Board of Chiropractic Examiners.

California M.D.'s do not mind certifying a patient as being ill, but they do hope they will not be handed the whole responsibility of determining whether he is actually too ill to perform his "usual and customary occupations." So it is likely that the California Medical Association will seek amendments to the act, during the 1947 legislative session, which would (1) rule out chiropractors as examiners under the act, and (2) limit the doctor's responsibility to certifying to the physical condition of the patient.

Meanwhile, the chiropractors say that when the program gets under way they will bring suit against the State Unemployment Stabilization Commission if any patients whom they certify are re-examined by anyone other than another chiropractor.

Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice. Address Medical Economics, Rutherford, N.J.



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Editorial

Let the Public Participate!

Organized medicine's relations with the American public are somewhat less than ideal. This has been evident at the recent hearings on the Wagner-Murray-Dingell bill. The proponents of compulsory health insurance have included representatives of many powerful public groups. The opponents of the bill have come almost exclusively from medical societies. This lack of broad public support, which is also suggested by various opinion polls, constitutes an obvious danger. We cannot preserve the private practice of medicine unless the public, which will make the ultimate decision, is won over to our viewpoint.

Unfortunately, organized medicine will never gain wide public support as long as it insists, as it does now, that it be recognized as the sole arbiter of what is best for the public. An important segment of the people finds this attitude unreasonable. It feels it has a right to participate in the planning of medical care. It is affronted when organized medicine denies it that right.

Advocates of compulsory health insurance, sensing that this cleavage between the public and the medical profession offers them a valuable opportunity, are doing their best to exploit it. Arthur J. Altmeyer, chairman of the Social Security Board, recently stressed the point that "consumers as well as doctors have the right to be heard and to participate actively in the planning for medical care," but that "consumers do not have these rights in the plans being organized and sponsored by medical societies."

Nothing is to be gained by denying that Mr. Altmeyer made a valid point. Organized medicine must now acknowledge that the public, which is vitally affected by the distribution of medical care, is entitled to some say in the matter. If it does not make this acknowledgement freely, the public will sooner or later take matters into its own hands.

Actually a partnership with the public in planning for medical care offers the medical profession its best hope for the future. If the public is allowed to share in the organization of private prepayment plans, it will defend these plans to the last ditch. Let organized medicine, therefore, place its relations with the public on a sound footing by inviting the public to join with it in building the voluntary prepayment movement as an alternative to state medicine.

—H. SHERIDAN BAKETEL, M.D.

Industrial Practice, 1946

Its opportunities and drawbacks as seen by doctors in industry

"Should I—or shouldn't I—enter industrial practice? If I do so, should it be on a part- or full-time basis?"

For answers to these questions, which many young physicians are now asking themselves, MEDICAL ECONOMICS has gone to men in the field. Their opinions, frankly expressed, provide a sound basis for summing up the specialty's advantages and disadvantages.

While the consensus seems to be that much depends upon the physician himself and what he is aiming at, it is also evident that the field should be judged in the light of all factors involved. What follows, therefore, is a resume of the major considerations, giving the pros and cons of each.

RESPONSIBILITY

Never his own boss, the industrial physician must trade the relatively greater freedom and higher earning power of the private practitioner for such advantages as regular hours, few night calls, steady pay, no overhead, and a certain sense of security. Thus, personal temperament—the ability to adapt oneself to the confines of a limited responsibility—is all-important. On the whole, industrial practitioners feel that the advantages of their practice outweigh the limitations.

VARIETY OF WORK

While some diagnosticians say they encounter many obscure ailments in industrial practice, the average M.D. finds that the bulk of his work consists of accident cases, pre-employment examinations, reduction of occupational hazards, and treatment of toxic conditions. In many of the plants, preventive care (through regular check-ups) is emphasized, and some doctors feel that this ultimately leads to too much routine. Surgery, of course, is limited to minor operations. Generally speaking, the field offers greater opportunity for diagnostic than for therapeutic work.

PROFESSIONAL RECOGNITION

Theoretically, unlimited opportunities exist for the collection and publication of case data—one of the best means of professional advance-

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▶ This article introduces a series on industrial medicine which will examine in detail the problem of how to obtain an industrial position, relations between industrial and private practitioners, special training needed for industrial practice, analysis of salaries and job opportunities, and other specific aspects of the industrial medical field.

---

ment. But often the opportunity goes unexploited because of the stultifying effect of routine. Moreover, promotion within the field is usually slow, though this may be attributed in part to the fact that many have entered industrial practice in the hope of finding security and "a soft spot." The impersonal analyst is inclined to agree with those who insist that gaining recognition in industrial medicine, as in private practice, is entirely up to the individual.

THE CAREER ANGLE

"Unless you're going to make it your life's work, stay out of a full-time job," those in the industrial field advise. They say that a few years as a salaried employe can ruin a man for private practice. The majority recommend part-time work—some contending that it aids in the building of a private practice. Others declare that the man who has the proper training and devotes his full time to industrial practice can find plenty of opportunity.

PATIENTS

Most industrial doctors find the lower-income groups interesting to work with and highly cooperative. It is pointed out, however, that the ratio of malingerers is high—and a nuisance; that personal conflicts among workers, particularly women, constitute something of a headache; that some patients have little respect for "the company doctor," and often argue about their ailments after "shopping" for outside medical advice; and that industrial practice is obviously no place for the physician who does not wish to care for Negroes.

FACILITIES

In the larger plants, medical departments are usually well equipped and adequately staffed. During a business slump, however, a company may be reluctant to purchase needed apparatus, or it may try to get along with too few doctors, nurses, technicians, and secretaries. Some smaller plants provide adequate space and equipment, but skimp on salaries or personnel. But generally facilities are better than the average private practitioner could hope to maintain in his own office.

PLANT OFFICIALS

Management policies vary greatly. Some officials follow a hands-off policy with the medical department, giving the doctor wide leeway in such matters as the granting of sick leave with pay, the placement of handicapped persons, and reduction of absenteeism. In other plants, a doctor's decision may be overruled by the personnel department. As a result, some practitioners claim to be at the mercy of the higher-ups. Others insist that management needs only to be convinced that the doctor is working *for* the plant—not against it—in recommending measures to improve the employes' health. The truth of the matter is that the physician must please both groups—management and workers—a circumstance which requires an unusual degree of tact.

ETHICS

Just where the company doctor's responsibility ends and the family doctor's begins is often a sore spot. The situation becomes involved if a patient comes to prefer the plant physician. Should the latter happen to be a part-time private practitioner, he may be accused of pirating patients. In states where workmen's

compensation laws do not allow free choice, an injured employe may be required to use the company doctor—who may soon find himself being called "unethical" by local physicians. The industrial practioner can best adhere to the code by limiting his work to preventive care, diagnoses, and first-aid treatment; by referring all possible cases to the family doctor; and by maintaining a friendly relationship with all local M.D.'s.

THE SPECIALTY'S STATUS

In the past, many doctors—feeling that acceptance of salaried work implied a lack of enterprise—were inclined to look down on industrial practice. Some still do—including part-time men in the field who regard industrial practice as a stopgap. This fact, together with the claims of patient-pirating and a general impression that a large number of incompetents are doing industrial work, placed a certain stigma on the specialty. But the stigma is disappearing. More and more medical schools are featuring courses in industrial medicine, and the number of men specially trained for the work is mounting. Salaries were increased greatly during the war, and this has attracted more high-caliber men to the field. As research widens and standards of practice improve, the specialty shows every indication of achieving equal status with the older and more popular practice categories. —NELSON ADAMS

Little Lazarus

Seven months pregnant, she appeared at the hospital firmly convinced her baby was dead. She'd felt no movement for days, she said, and had been vomiting frequently. My examination tended to confirm her belief: I could detect no movement, no fetal heartbeat. Besides that, she had a record of a couple of still-births. So I dilated the cervix and packed it, with the pious hope that the dead fetus would be expelled.

Next day, however, my patient declared that her baby was alive. Again my examination supported her: I now found fetal heartbeats and movement. Hastily I removed the packing, had the woman stay in bed for another twenty-four hours, and then discharged her.

Shortly afterward, her husband appeared in my absence and truculently demanded to know why the doctor had decided "to operate" when the baby was alive. "Look," snapped my quick-witted nurse, "I think you're the most ungrateful man I ever met. Your wife came in sick, with a dead baby. Now, thanks to the doctor, it will probably be born fine and healthy at the proper time."

It was, and I officiated at the delivery. For the couple now regarded me as nothing less than a miracle man. —J. W. BROWN, M.D.

Quiz

[*Answers on page* 110]

1. Number of women doctors in the U.S. approximates
   a. 1,000 b. 4,000 c. 8,000 d. 12,000

2. "Cat fever" is the Navy doctor's abbreviation for
   a. Fever induced by application of cathode ray
   b. Fever accompanying a cold in the head
   c. Suspected yen for off-limits female
   d. Reaction to cat fur

3. An M.D. is responsible for an interne's negligence
   a. If his private patient is involved
   b. If interne gave treatment under his direction
   c. At all times
   d. Never

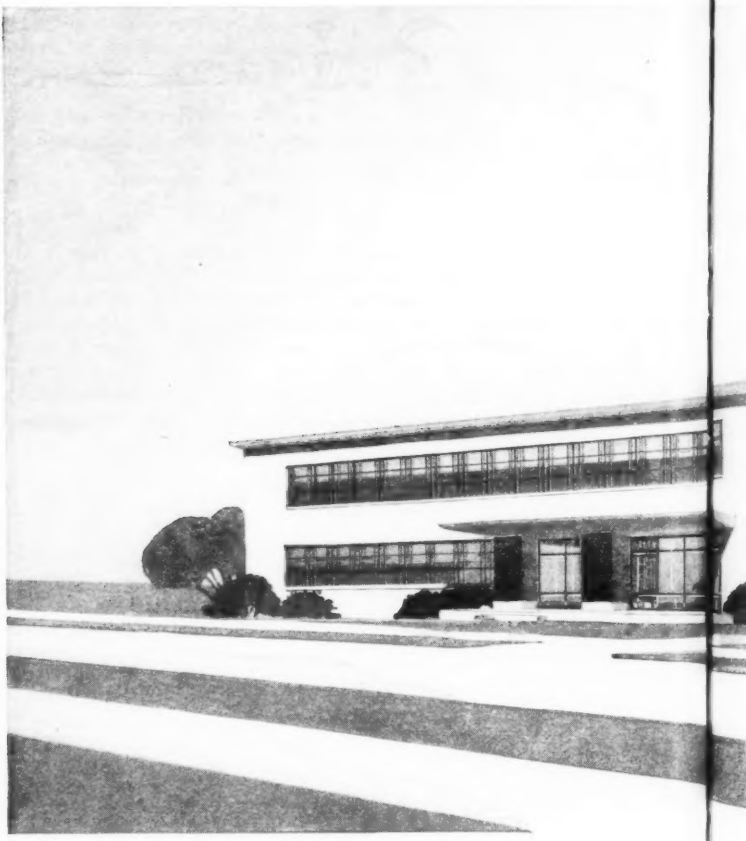
4. Paracelsus was
   a. Swiss b. Italian c. Greek d. Prussian

5. The thyroid gland is so-called because
   a. It was first described by Theodore Thyros
   b. It is near the thyroid cartilage
   c. It is shield-shaped

6. Elizabeth Blackwell was
   a. First woman doctor in the U.S.
   b. Founder of the mental hygiene movement
   c. A dean of the Women's Medical College
   d. Maiden name of Sister Kenney

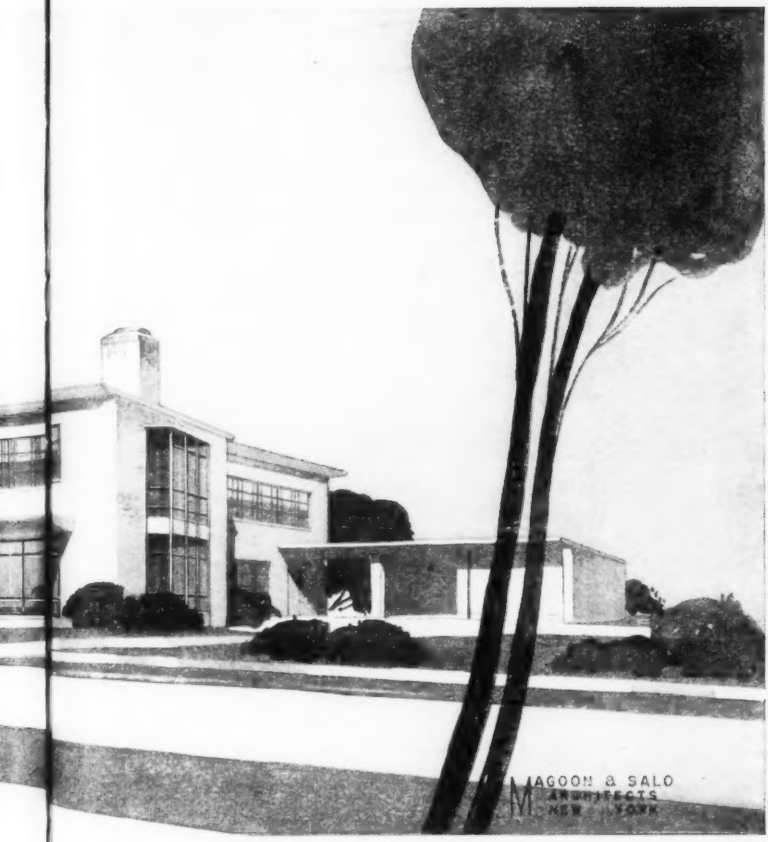
7. Hippocrates was born in
   a. India b. Cos c. Thessaly d. Macedon e. Brooklyn

8. First medical school in the U.S. was at
   a. William and Mary b. University of Pennsylvania
   c. Harvard d. Bowdoin e. Kirksville, Mo. f. Yale



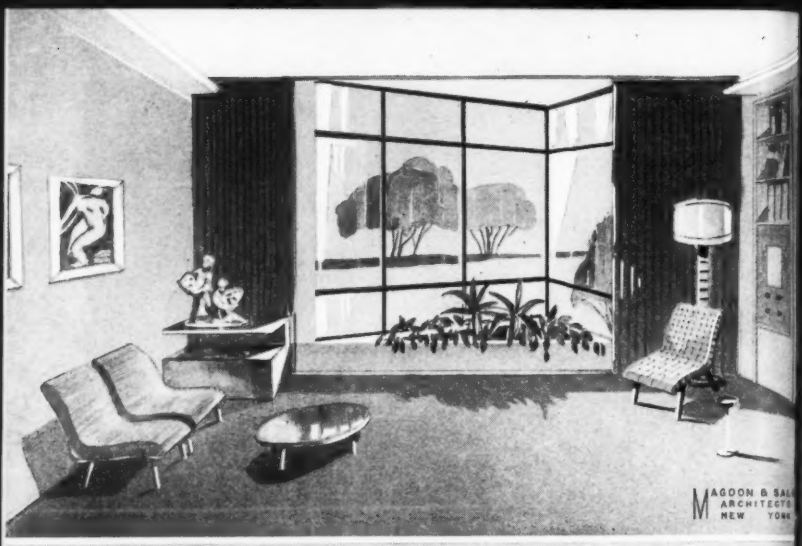
Modern Design for Four to Eight Physicians

▶ From the boards of Magoon & Salo, who were commissioned to design the medical building described in these pages, have come architectural plans for a variety of physicians' offices. Other recent work of this firm includes the new Riverside Health Clinic and additions to the Fort Schuyler hospital, in New York City.



This forward-looking medical office building has been planned to accommodate four doctors in a one-story structure or eight doctors in two stories. In its one-story stage, it provides separate offices but common reception rooms for (1) an EENT man; (2) an internist; (3) an obstetrician-pediatrician; and (4) a surgeon. For their purposes, the floor plan has been rather extensively developed (see cut). If a second floor were added, its layout would be determined by the requirements of the specialists it was to house.

The exterior elevation (above) shows the building as it would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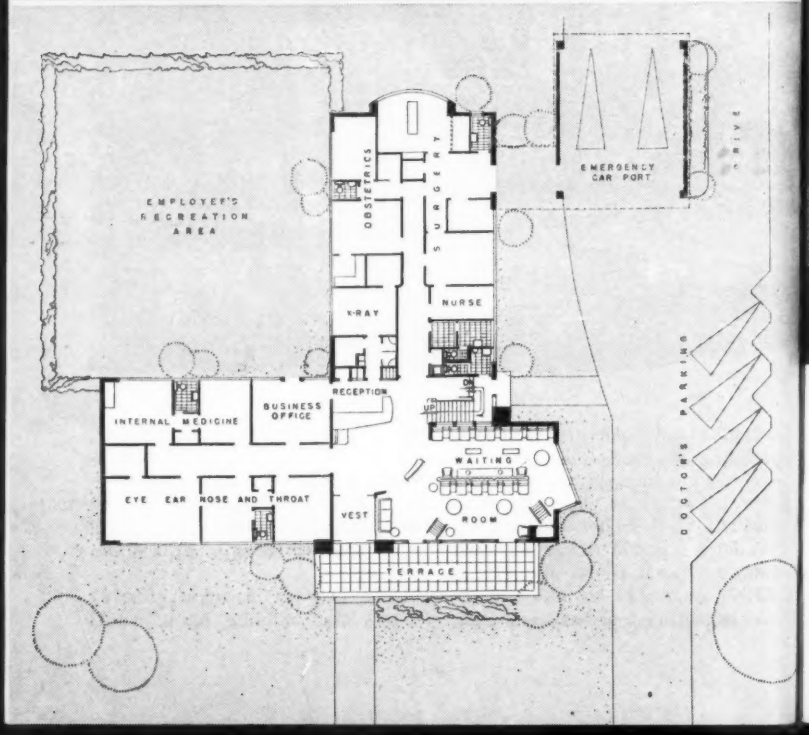
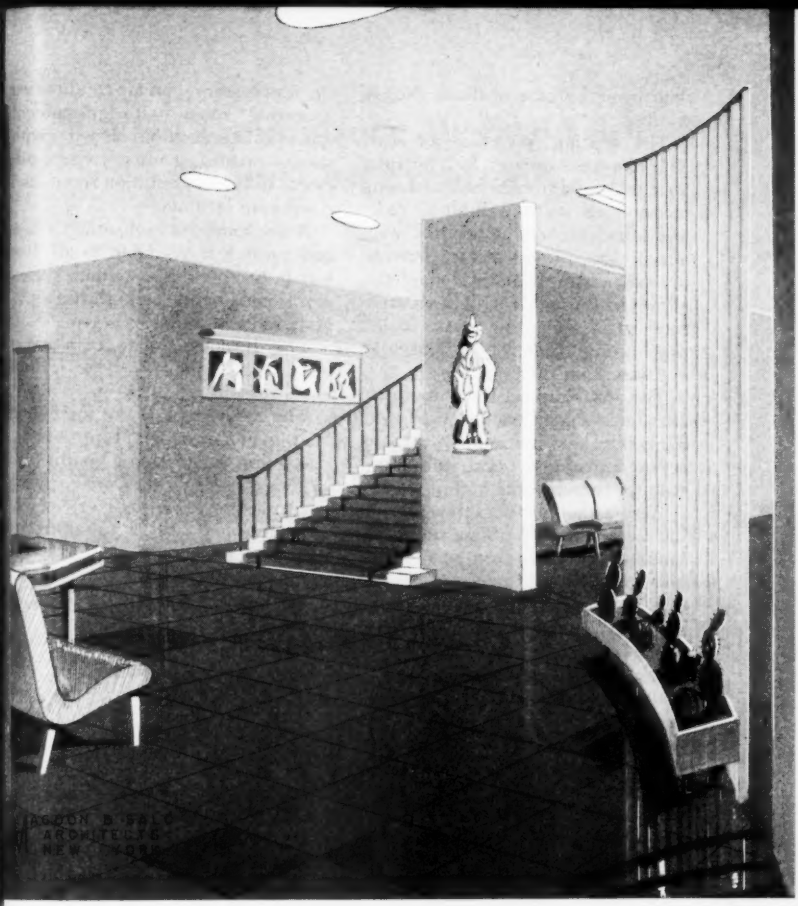

EMPLOYEE'S RECREATION AREA
OBSTETRICS
SURGERY
EMERGENCY CAR PORT
DRIVE
X-RAY
NURSE
RECEPTION
INTERNAL MEDICINE
BUSINESS OFFICE
WAITING ROOM
EYE EAR NOSE AND THROAT
VEST
TERRACE
DOCTOR'S PARKING



eventually appear, but the reader may easily visualize the one-floor stage, for it terminates at a parapet which would correspond with the sill of the long horizontal windows.

The patient approaches the building by way of a paved, covered terrace. Through a vestibule (which acts in winter as a buffer against cold), he passes into a roomy lobby faced by a large reception desk. There a receptionist may direct him either to a physician or to the waiting room, which lies beyond a corrugated-glass screen (see drawing above). The glass screen has functional value in that it secludes the receptionist and the entering pa-

tient from the gaze of those already waiting.

The waiting room has an easy, club-like atmosphere. It is artfully arranged to eliminate embarrassing face-to-face seating. Built-in radio and television sets, as well as magazines, are provided for patients' diversion. Ample natural daylight, admitted through corrugated structural glass and clear glass, bathes the waiting room, lobby, vestibule, and stair hall.

The suite of the EENT man consists of a central consultation room flanked by an eye examination room, a nose-and-throat room, and a private toilet and closet.

Across the corridor, the internist has a consultation room, an examination-treatment chamber (which also contains his package laboratory), and a combination dressing room-lavatory which may be used by patients in transit while the physician is engaged elsewhere.

The obstetrician has a similar suite. His treatment room is somewhat smaller, but he has a separate laboratory as well as separate lavatory and dressing rooms.

A rather more extensive layout is required for the surgeon. He has a consultation room, a chamber for scrub-up (and emergency anesthesia, if necessary), an air-conditioned operating room with instrument space, a sterilization alcove (with storage space), a nurse's space adjacent to the consultation room, and a separate lavatory.

A car port for unloading emergency cases is available to all doctors in the building. A small recovery room is handy to both the operating room and the car port.

The business office is situated near the receptionist's desk, for obvious reasons.

The X-ray department includes a lead-lined X-ray room, control room, dark room, two dressing booths, and clothes lockers. There are separate lavatories for the sexes. For women, a vanity shelf and a full-mirrored wall have been provided.

A parking space for physicians and a separate entrance have been placed in a secluded spot.

The building is constructed of light brick and structural glass, with limestone trim and steel casement windows. Interior walls are of plaster with sanitary, curved bases; ceilings are of acoustical tile and floors of asphalt tile.

One-floor construction (73,700 cubic feet) would cost about $70,000 at today's prices; two stories (125,700 cubic feet), $120,000.

Tooth and Nail

The elderly woman—an industrial patient—had a finger infection. As I examined it, I noticed that all her fingernails were cropped almost to the quick. "Oh, oh!" I said reprovingly, "You've been biting your nails!" The patient looked at me condescendingly, opened her mouth wide, and drew back her lips. There wasn't a tooth in her head.

—JOSEPH REITER, M.D.

What Compulsory Medical Care Would Cost Eventually

Federal estimates unrealistic, says analyst, predicting a vast pyramiding of costs

In discussing the cost of a nation-wide system of private prepaid medical care (MEDICAL ECONOMICS, May), I estimated the potential market at 70 million people, the average annual cost at $30 per capita, and the total annual cost at $2,100,000,000. The above estimate omits the upper income brackets, the very low income classes, the institutional population, and special groups like the veterans. It also omits most of the rural population because of the difficulty of distributing private medical care in rural areas.

A compulsory system of hospital and medical care would cover a larger part of the population, between 100 million and 120 million out of a population of 140 million. Under the proposed Wagner-Murray-Dingell bill, only those groups such as the institutional population, some of the veterans, some of the aged and retired, members of the armed forces, and some of the school population would be excluded.

Thus, the compulsory system would be more comprehensive than a private system. But it would also be more expensive. Just how much would a compulsory system of hospital and medical care cost? Those who have proposed such a system have stressed the desirability of health insurance for everyone, but they have not adequately stated the problem of cost. What can the nation afford in the way of compulsory health insurance? How much can the Government promise

▶ The author, Gerhard Hirschfeld, is director of the Research Council for Economic Security, a privately supported organization with headquarters in Chicago, whose board of trustees includes officials of B. Kuppenheimer & Co., Sears Roebuck & Co., and the Public Service Company of Northern Illinois. The council has completed a number of factual studies on social security, the results of which have been published in the Journal AMA, the American Sociological Review, the Quarterly Journal of Economics, and other organs. Each study is designed to present all aspects of the subject, for the council holds that much of the available information on social security is one-sided, dealing chiefly with benefits but ignoring costs and other economic drawbacks.

in benefits that the people have to pay for in taxes? These and other questions are ignored by the proponents of compulsory health insurance.

COST ESTIMATES

At various times estimates have been made as to the cost of compulsory medical and hospital care. In his book, "Insecurity—A Challenge to America," Abraham Epstein estimates that 5 per cent of the wages of insured persons is necessary for complete health insurance (3.75 per cent for hospital and medical care and 1.25 per cent for temporary disability benefits).

In his message to Congress, President Truman stated that a 4 per cent payroll tax would be sufficient to finance a compulsory system of hospital and medical care.

In a study for the Milbank Memorial Fund, Isidore S. Falk and John Kingsbury estimated the cost of compulsory hospital and medical care at 4.5 per cent of payrolls.

Obviously, the tax yield depends upon the employment and wage level. A 4 per cent payroll tax conceivably may have a higher yield in a period of prosperity than a 5 per cent tax in a period of depression. Yet, while the business cycle is of decisive importance, it seems to have been given little, if any, consideration in the various tax proposals. Considering the importance of the business cycle, it may be well to assume that the average tax rate required for the financing of compulsory medical and hospital care is 4.5 per cent.

Based on last year's national income of $161 billion, the total taxable income would amount to roughly $100 billion, 4.5 per cent of which would amount to $4.5 billion. This would be the annual cost on paper of a national system of compulsory health insurance. Assuming a total coverage of between 100 million and 120 million people, the per capita annual average cost would thus be between $37.50 and $45.

In reality the cost is likely to go far above this estimate. For one thing, cash benefits for wage loss due to temporary disability will in due time become part of a compulsory system of medical and hospital care, if they are not included at the outset. It has been thus in every country that has tried such a system. Such cash benefits will cost no less than 1.5 per cent of payroll and, more likely, 2 per cent.

The inclusion of cash benefits would raise the estimated cost from $4.5 billion to $6 billion a year.

There are still other costs, as Elizabeth W. Wilson pointed out in "Health Insurance: Costly Experiment" (Christian Science Monitor, March). Under the Wagner-Murray-Dingell bill of May 1945, physicians, dentists, and nurses may require each patient to pay a small fee. Moreover, if dental and home-nursing benefits are not available as determined by the Surgeon General, the worker or his family may have to pay for outside services. The maximum period of hospitalization is 60 days; if the worker needs hospitalizaton for a longer period he has to pay for that, too.

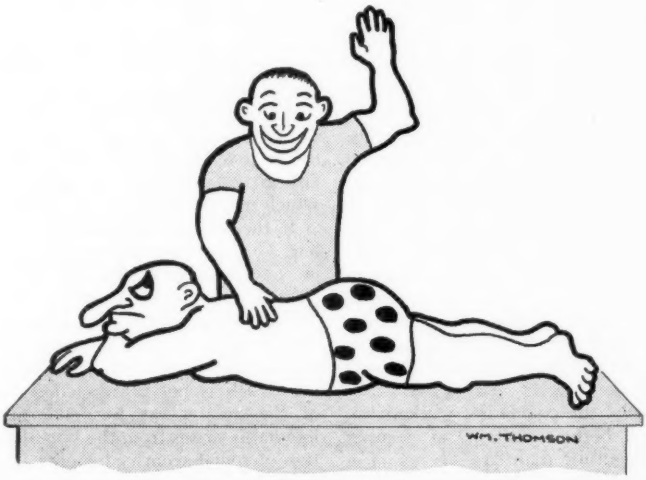
If the worker does not like the insurance doctor in his neighbor-

hood, he must go to a private physician. According to Mrs. Wilson, "In 1936 about 600,000 British workers renounced their right to medical care under the insurance system by failing to register on the panel. In the same year, one-third of the British workers who were eligible for insurance did not qualify for it" (Barrons, April 8). All these factors combine to make government health insurance far more expensive than paper estimates would indicate.

FOREIGN EXPERIENCE

Unfortunately, the experience of foreign countries cannot be applied directly to the problem in our own country. Standards and conditions, both social and economic, are so basically different that a direct comparison is practically impossible. Therefore it means little to say that benefit payments under compulsory health insurance in Germany amounted in 1930 to Reichsmark 1,650,000,000, or about RM 37.50 for each beneficiary. Similarly, it adds little to state that in Great Britain the cost of compulsory health insurance in 1930 was £34,722,600, or an average of nearly £2 per beneficiary.

Of far greater importance is the enormous rise in the cost of health insurance on a compulsory basis. In Germany, sickness insurance expenditures per member were RM 12.16 in 1885, RM 26.82 in 1910, and RM 93.64 in 1929. The rise was so pronounced that the Reichstag was forced to consider special measures to halt it. Imposition of an extra payment of about 25



"PAT-A-CAKE, PAT-A-CAKE, BAKER'S MAN . . ."

pfennig for prescriptions and consultations proved an effective measure: By 1933, costs had dropped to RM 59.69.

The cost development was similar in Great Britain. Sickness insurance expenditures per member increased more than 150 per cent between 1912 and 1927.

Two basic reasons account for the fact that cost can be controlled under a private system but cannot be held to a stationary level over a long period of time under a compulsory, federally-administered system. One is the human factor which insists upon claiming benefits regardless of whether sickness is real or imagined. An intangible quality, it is nevertheless of the greatest influence upon cost.

When compulsory health insurance was introduced in Germany in 1885, the average illness lasted fourteen days. By 1932, it had stretched to twenty-nine days. Better diagnoses, larger hospital facilities, health education, tuberculosis and cancer drives, and other factors may partly explain the increase. But there is little question that malingering has played a major part in extending the period of illness, real or imagined. Mrs. Wilson holds that malingering would be worse in this country than in Great Britain because here the system would operate under a Federal bureaucracy, whereas in Britain cooperative groups of workers manage benefit payments. Obviously, she concludes, workers are in a better position to combat malingering than are agents of a democratic country.

The human problem is emphasized by the experience of the cash sickness plan in Rhode Island. After more than thirty months of operation, the Unemployment Compensation Board reports that during 1945 about 25,500 appointments for medical examinations were made. This compares with 32,000 beneficiaries in the first benefit year which ended March 31, 1944. Of these 25,500 claimants, about 22 per cent failed to appear, 19 per cent of the claims were denied, 53 per cent were allowed, and 6 per cent were deferred for benefits. The high figure of 41 per cent of claimants who received no benefits, because of denial or failure to appear, indicates the overeagerness for benefits.

Of course, malingering is not confined to compulsory health insurance. It has been a major problem in the private insurance business, especially in health and accident insurance, and has been reflected in absenteeism in industry and in the operation of the public works program during the 'thirties. The important difference is that a fair measure of control is possible under private systems, but is difficult to attain under a system in which political influence is a factor.

If the human equation is Problem One in the cost development of compulsory health insurance, political interest is Problem Two. The prospect of broader coverage (longer periods and higher amounts of benefits) is pleasing to the public, which is not always conscious of the greater tax burden which inevitably arises from the liberalization of social security benefits. The politician who persisted in opposing the popular demand for such liberalization, would quickly find

himself in disfavor.

It is largely because of political interest that the history of social security in Germany, Great Britain, and other countries is studded with measures creating additional social services. The writer sees no reason why this experience would not apply equally to our own country.

There are those who believe that the total annual cost of social insurance in the United States will ultimately take about 25 per cent of the national wage bill. This is the same percentage estimated to be necessary for the proposed expansion of the British system.

The outstanding lesson to be learned from compulsory health insurance abroad is the extraordinary influence of human behavior and political interest upon the cost development. The same factors would play a major part in compulsory Federal health insurance in this country, with the possible difference that both the human and the political factors may operate here on a more generous scale than they did in Germany or Great Britain. If such a system were adopted in the United States, it would cover more people and pay higher benefits than similar systems did in any other country.

Therefore, if on paper the annual cost of compulsory health insurance, including disability compensation, in the United States would be about $6 billion, the ultimate cost after ten or fifteen years would be still higher. And this not so much as a result of maladministration, an inefficient system, or poor handling of claims, but as a result of the human and political intangibles involved—intangibles which compulsory insurance has not yet been able to master, but which the private system has kept under control, or kept away from, for many years.

If foreign experience is any criterion, the cost of compulsory health insurance, if and when it comes, will find its ultimate determination not so much in the cost of services—hospital, drug, or prescription—but in terms of what the people think they should receive in benefits and what the politically minded think they should give the people in broader coverage, larger payments, and greater all-around protection.

Over the years, it has proved extremely difficult to either limit or to break the selfish human or political impulses. They constitute the most important cost problem, and one which is not solved by a shrug of the shoulders on the part of the proponents of compulsory health insurance. —GERHARD HIRSCHFELD

Drip

A young man came into the hospital emergency room to ask for a blood test, admitting—after considerable beating about the bush—that he thought he had a venereal disease. I asked if he had a discharge. "Oh, sure," he replied, reaching into his pocket, "I got one from the Marines a month ago!"—M.D., OHIO

Government to Scrutinize Tax Returns of Physicians

Wide drive to run down "evaders" begun by Bureau of Internal Revenue

The Bureau of Internal Revenue has launched the most extensive campaign in its history against income tax evaders—the negligent as well as the dishonest. Last month the Treasury Department announced that it had enlisted the services of the Department of Justice to assist the bureau's already active investigating agents.

The drive is directed at all income tax evaders regardless of occupation. But professional men, whose income is not fixed and regular and may come from many different sources, are especially liable to questioning.

Ordinarily, so as to keep informed (and as a warning to the potential evader), the bureau routinely investigates a certain percentage of returns. During the current drive the percentage will be higher than in any previous year, principally because of greater negligence on the part of taxpayers and because of the greater incentive to fraud, stemming from high tax rates. Obviously, when the check indicates that fraud has been attempted, investigation will follow.

Concerning doctors, one revenue agent told this reporter that the bureau could not rely upon the complaints of associates to turn up even a small percentage of income tax evaders. A physician, he said, may tell other doctors how he "beat the Government" and his listeners may be resentful; but they won't report the offender and risk damaging the status of the profession at large. Hence, the Government has to rely primarily on its own "fishing" expeditions.

While the bureau has many undisclosed methods of investigation, there are a number of general approaches that may be described. First off, it may compare your current return with those of previous years. If there is any large difference in income it will want to know why. If you cannot satisfactorily explain it, you will be in for an immediate check-up.

Again, revenue agents may look for evidence that an individual is living beyond his stated income. Once more, you must explain satisfactorily or face investigation by the bureau.

In another instance, the bureau may compare a man's deductible expenses with other available records, perhaps his statement of what he paid a nurse against the total indicated by her withholding tax return.

Any failure to report income can

be checked, of course, by running down medical-service deductions claimed by patients' on *their* income tax returns, for each must give the physician's name. A few years ago a surgeon was arrested for fraud when an agent, going over his books, found no record of a $600 fee claimed by a patient as a deduction. The doctor vigorously denied that he even knew the patient until he was finally confronted with the records of the hospital and with the patient himself.

Every year the bureau examines records of real estate transactions. If it finds a man has paid a large sum for land or buildings it may want to know whether the money was legitimately accumulated capital or cash siphoned off and never reported as taxable. The bureau also makes use of a chart showing average incomes of physicians in each area of the country. Thus, if an income report is abnormally low, it may be followed by an inquiry into the doctor's books.

"If a doctor is not honest," a bureau agent told this writer, "he may think that he can keep two sets of books or that he can merely forget to enter patients' fees as income, figuring that there will be no way to check up on him. Such action presents a difficult problem to tax collecting officers, but the violator is not infrequently discovered. In one recent case the defendant was a doctor who had filed returns for two years showing income of around $18,000 a year, when in reality his yearly income was over $30,000. He had kept two separate sets of books —one true, the other false. The false books, which he made the basis of his income tax returns, included only a portion of his fees. The Bureau of Internal Revenue learned about this through anonymous telephone calls which turned out to come from the doctor's nurse. Eventually she turned him in, with the result that he was tried and received a substantial prison sentence for his deception."

Suppose you have filed a return which, to the best of your knowledge, is accurate, yet you lack records that could prove you are right. Suppose, next, that your return is one selected at random for investigation. In that event, the bureau will place the burden of proof squarely on your shoulders. It believes that an honest doctor should be able to furnish records that substantiate his income report (for such purposes even a diary or notebook may be considered adequate) and if such proof is not forthcoming it must invoke a penalty.

Its first step in such a contingency will be to assign an agent to observe your practice. After a few days, he will assess a tax based on his observation, and he will make that assessment high just in case your practice may have slacked off. Perhaps he may disallow expense deductions, pending adequate proof. With assessment made, you have the choice of paying the high, arbitrary tax, plus interest and a penalty, or of producing records of income and expense to substantiate your original claim and prove the Government assessment unfair. It's a Hobson's choice if you don't have the records. What's more, your troubles may only be beginning. For now the Government may ask you to substantiate the returns you submitted in earlier years! —JEFFREY NORTON

The Nicollet Clinic

It continues, in its third decade, to exemplify the best in private medical group practice

No discussion of group practice gets far without mention of the name Nicollet. Like a number of other names—Summit, Ross-Loos, Duluth, and Sheboygan—Nicollet represents group practice tested over a stretch of years. Its pattern may well be that of new groups that will emerge in the wake of World War II.

Nicollet itself was an aftermath of World War I. It was founded in 1920 by ten physicians who had been engaged in private practice and teaching and were later associated on the staff of the Army's Base Hospital 26.

The Nicollet Clinic is situated in downtown Minneapolis, in the heart of that prosperous city's shopping district. Its seventy-four rooms on the big second floor of a two-story building house twenty-two physicians who provide general and specialist care for an average of 300 patients a day. Sixty per cent of the patients come from Minneapolis itself, 40 per cent from a surrounding area approximately 250 miles in radius.

They are offered a wide range of services in the office, home, or hospital: internal medicine, general

The clinic occupies seventy-four rooms on the second floor of this business building.

surgery, orthopedic surgery, plastic surgery, pediatrics, X-ray, EENT, obstetrics, gynecology, pathology, dentistry, urology, neuropsychiatry, and dermatology. Each specialist is an American board diplomate; his juniors are preparing for their boards. At the disposal of each is the most complete and modern equipment that can be bought.

The bulk of Nicollet's patients require the services of only one general practitioner or specialist. A survey in one year indicated that 63 per cent of the patients were examined or treated by a single physician; that 21 per cent visited two physicians; and that 16 per cent visited three or more during the course of diagnosis and treatment.

The group believes that the personal relationship between doctor and patient is enhanced rather than diminished by Nicollet policies. Most patients ask to see a specific doctor who has treated them before or one recommended by a friend. Even when the request is an illogical one (a patient with an ear disorder may ask to see an internist), the registrar makes no effort to orient him, but arranges that he see the doctor of his choice for the initial visit. The physician, in turn, talks with the patient and introduces him to the indicated doctor.

"There is always a smooth continuity which aids the patient's peace of mind," comments one Nicollet physician. "He is never *sent* to see some other doctor, he is taken to him and introduced. Few solo practitioners could undertake to do that."

About one in four of the clinic's patients are referrals from outside physicians for diagnosis or for diagnosis and therapy. Few referrals come from the immediate Minneapolis area. There is a feeling among doctors in the city that they might "lose" their patients to the clinic. That problem is a knotty one, although Nicollet adheres to a rigid policy of returning all referrals to the outside physician.

Nicollet physicians probably earn more and work fewer hours than comparable solo practitioners in the area, because of lower overhead and other factors. But the patient pays no more for his medical care. Frequently he pays less. This fact stems from a settled policy of the group. More than a decade ago, its members made a thorough study of the costs of medical care, as exemplified in their own clinic. "We found," says Alfred G. Stasel, business manager, "that we, like everyone else at the time, were giving too little consideration to the economic circumstances of the patient, relying instead on the doctor's brief acquaintanceship with him to determine the final fee. We found that we were being more unfair than fair. Disturbed,

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▶ Because of the profession's increasing interest in group practice, and because of the significant changes in American medicine which any wide development of group practice would bring about, MEDICAL ECONOMICS has undertaken an extensive study of the subject and plans to publish the results in a long series of articles. Second in the series is this description of the Nicollet Clinic, an outstanding example of its kind.

HOW NICOLLET CLINIC FITS FEES TO PATIENTS' MEANS

PATIENTS' ECONOMIC STATUS

AAA: Net worth over $250,000; income in excess of $25,000.
AA: Net worth $100,000-250,000; income $15,000-25,000.
A: Net worth $50,000-100,000; income $10,000-15,000.
B: Net worth $15,000-50,000; income $5,000-10,000.
BC: Net worth about $10,000; income $2,500-5,000.
C: Net worth $5,000 or less; income $1,500-2,500.
D: Net worth zero; income less than $1,500.

ADJUSTED CHARGES

Standard Schedule	AAA	AA	A	B	BC	C	D
$10	$10	$10	$10	$10	$10	$7.50	$5
11	11	11	11	11	10	7.50	5
12	12	12	12	12	10	7.50	5
13	13	13	13	12	10	7.50	5
14	14	14	14	14	10	7.50	5
15	20	15	15	15	12.50	10	7.50
16	20	16	16	16	12.50	10	7.50
17	20	17	17	17	12.50	10	7.50
18	20	18	18	18	12.50	10	7.50
19	20	19	19	19	12.50	10	7.50
20	25	20	20	20	15	15	10
21	25	21	21	21	15	15	10
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65	75	70	55	50	45	35	30
66	80	75	60	55	45	35	30
67	80	75	60	55	45	35	30
68	80	75	60	55	45	35	30
69	80	75	60	55	50	35	30
70	90	80	60	55	50	35	30
71	90	80	65	60	50	40	30
72	90	80	65	60	50	40	30
73	90	80	65	60	50	40	30
74	90	80	65	60	50	40	30
75	90	80	65	60	50	40	30

we sat down and figured out a system based upon two factors: the establishment of a fee schedule based on prevailing charges in the area; and a precise method of adjusting those fees upward or downward to the patient's ability to pay."

The accompanying table was the result. The patient's economic status is determined by commercial credit reports of his net worth and income. His status, applied to the table of adjustments, determines what fee he is to pay. Since all adjustments are made in the business office, the fee has no bearing whatever on the quality of service.

This adjustment policy and a post-payment budget plan (some 500 such accounts are currently active) have made for a 98 per cent collection rate. Eighty-five per cent of Nicollet's transactions are on a credit basis; 15 per cent are cash. Five out of every 100 patients are indigents who pay nothing.

The Nicollet Clinic does not have a prepayment plan of its own, but it participates in a commercial one. Mr. Stasel believes that while the group's policy of adjusting fees to income is a step in the right direction, "the social and economic problems of medical care, particularly in the low-income families, are difficult to solve except through budget or prepayment programs."

The clinic is operated as a partnership. All partners are physicians. Twelve senior members have a capital investment in the group and voting power in determining its policies. Together with three junior associates who do not have voting power as partners they share the earnings of the group after all operating and sinking fund expenses have been met. Three assistants and four fellows—young men in training for their American boards—are on a salary basis. The business manager has a voice in both administration and policy-making. Professional and business policies of the group are determined by an executive board made up of two doctors (elected yearly) and the business manager. The latter is in complete control of financial administration.

Through a trusteeship arrange-

Pantie Hurdle

The woman had come in with her husband for a vaginal examination. I led them to an examination room (the husband insisted on coming) and said: "Please remove your panties. The doctor will see you in a few moments." I had hardly closed the door behind me when it was opened by the husband. "Don't let the doctor see my wife until I get back," he said and dashed out of the building. In no time at all he had returned with a small package which he carried into the examination room. A few minutes later, when the doctor and I entered, a brand-new pair of panties—with the price tag still attached—were lying on a chair.

—FLORENCE STERLING

ment, Nicollet controls and staffs the 125-bed Eitel Hospital, about eight blocks away. That institution, erected as a private hospital, was bought by members of the Nicollet group in 1929 and reorganized as a charitable trust under the laws of Minnesota. When conditions permit, the group plans to expand Eitel by fifty beds. Nicollet practitioners are on the senior staffs of three other hospitals and on the courtesy staffs of seven. Conversely, Eitel offers courtesy staff privileges to several hundred doctors in the area. In a normal year, half its patients are admitted by Nicollet men, half by outside physicians.

The group owns a pharmacy located on the first floor of the clinic building. It is open to the general public and carries none of the usual drugstore sidelines. Clinic patients are free to have their prescriptions filled anywhere they choose, but most of them use the Nicollet pharmacy.

The group finds its present quarters, which it has occupied since 1920, somewhat inadequate in size, so it plans to erect its own building on a plot adjacent to Eitel Hospital. At present, each physician has a private office and adjoining treatment room. The rest of the seventy-four rooms are required for pathology, X-ray, electrocardiography, basal metabolism, physiotherapy, dressing, business, etc.

Nicollet maintains a large library, supervised by its medical secretary. Staff members prepare some thirty articles a year for specialty journals. These are abstracted for the Nicollet Bulletin which goes out quarterly to about 2,000 physicians in northwestern Minnesota.

Nicollet physicians see all but emergency cases by appointment. The clinic is closed evenings and on Sunday; telephone calls then are routed to Eitel Hospital, whose residents are prepared to make house visits in emergencies. If necessary, they summon the group physician in charge of the case.

Besides its twelve registered nurses, Nicollet's staff includes a correspondence secretary, bookkeeper, two assistant clerks, cashier, registrar and assistant, two laboratory technicians, two X-ray technicians, switchboard operator, elevator operator, janitor, and two cleaning women.

Nicollet physicians were once questioned by Dr. John H. Musser in a study for the Julius Rosenwald Fund. He asked them why they liked group practice and reported his findings as follows: "One mentioned freedom from personal economic responsibility and the opportunity of cooperating with experts in other lines. Another enjoyed his work because he felt he was giving better service to the patient at lower cost than if he were practicing alone. Still another emphasized that, although individual practice might have produced a larger intake, the advantages of cooperating with a group of congenial associates more than compensated for any possible increase in income. A fourth physician felt that patients were getting much more service than they did formerly and that the work was being done more quickly and more efficiently than with the time-consuming and expensive methods of individual practice. For example, the blood examinations, the dental examinations, some of the X-ray and

other special studies could be done in the clinic, whereas to send a patient from one specialist to another, from a clinical laboratory to an X-ray laboratory, would necessitate much delay. One member of the clinic particularly liked the stimulating professional association with the members in other branches of medicine, as his own specialty offered few opportunities for contacts with patients.

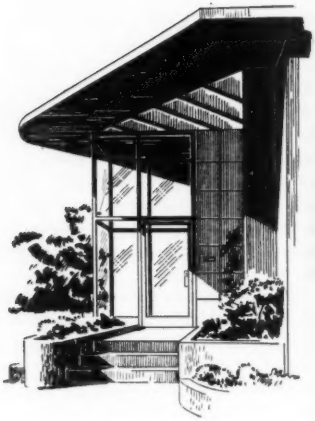
"The foregoing expressions," concluded Dr. Musser, "indicate that a clinic physician must emphasize certain characteristics, such as unselfishness, consideration of others, and a willingness to forgo individual wishes for the good of the group. There are some medical men who possess highly individualistic tendencies; it would be impossible for them to submerge their personal vanities and prerogatives sufficiently to cooperate well with others."

No retirement income plan has been established at Nicollet, although one is contemplated. When a partner-member dies, the group buys back his shares, using funds derived from an insurance policy on his life. By virtue of this arrangement and a special clause in the limited-partnership arrangement, the deceased man's estate can have no claim on the group or on its accounts receivable.

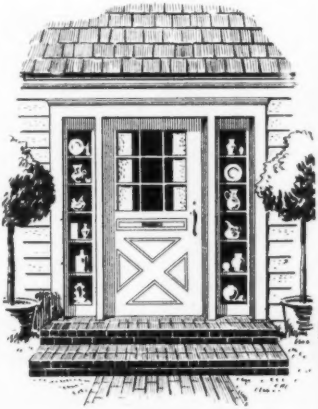
Enjoying a forty-hour week, the Nicollet practitioner also gets a vacation of from three to six weeks, depending upon his status, and time off for post-graduate work. All members must belong to the county medical society. —ARTHUR SODERBERG

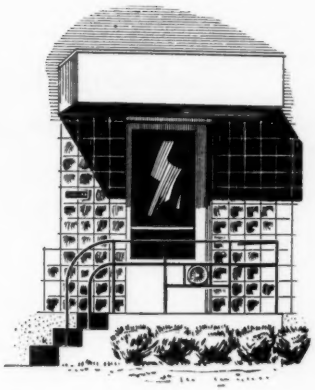
SUBJECT:

Doorways

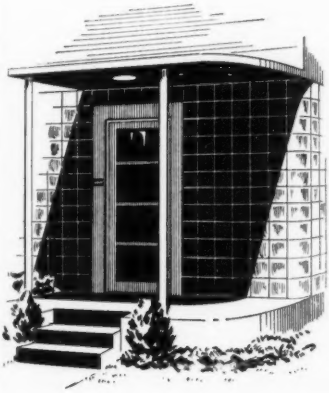


You'll do well to give more than passing attention to doorways, if you are planning to rebuild or remodel. For if you think back you'll recall having seen more than one nondescript building "pulled together" and dignified by a gracious doorway. And you'll remember others whose good architecture has been weakened and distorted by an ill-fitting entrance. That's not to suggest you design your house





around your doorway, though it's been done. Seek good basic design and good all-over harmony and you won't go wrong. Here are doorways which fall into three types: traditional, informal, and modern. They have been selected for their sound basic design and beauty of detail. Set one off with well-chosen shrubbery and you'll know that your home or office always has its best foot forward. —JOHN G. SHEA



Radiologists Issue New Code on Ownership of Films

Rights of referring physicians are clarified in ten-point statement

Legal rights and ethics involved in the ownership and use of roentgenograms have long been a source of trouble to radiologists, referring physicians, and hospitals. To clarify matters for all concerned, the board of chancellors of the American College of Radiology has announced the following ten-point statement of policy, adopted after study of the problem by a special committee:

1. Roentgenograms should be used for the patient's best interest.

2. Roentgenograms are the legal property of the radiologist or of the hospital in which they were made. It is advisable, but not necessary, to mark on each film the statement, "Property of Dr. John Doe." Such a mark is particularly desirable if the radiologist delivers the films to the referring physician instead of filing them in his own office or hospital department.

3. It should be the policy of the radiologist to make the films available for inspection by the physician who referred the patient for X-ray examination, along with a copy of the report of the radiologist. The best results are undoubtedly secured when it is possible for the radiologist and the referring physician to confer personally when the latter views the films.

4. If the referring physician (or the patient in behalf of the referring physician) wishes to take the films away from the office or the hospital, it should be clearly understood that the films are loaned and must be returned after the loan has served its purpose.

5. If the patient dismisses the referring physician and goes to another physician, the films and the report should be made as freely available to the second physician as to the one who originally referred the patient. It is desirable that the patient notify the first physician of the change, and it may be assumed that he has done so; but even if this notification has not been made, the obligation of the radiologist is unchanged. When the second physician wishes to examine the films, it is assumed that he is doing so at the request of the patient.

6. If the referring physician objects to having the films made available to the second physician or to giving the latter a copy of the radiologist's report, the radiologist remains obligated to do so. If the referring physician has possession of the films and refuses to release them, the radiologist, whose legal property they are, has the right to take whatever action is necessary to

get the films for the further benefit of the patient.

7. All films should be legibly and permanently marked so that the patient can be identified and the date on which they were taken can be determined. This is important because, under some conditions, a comparison of films just made with others made previously may be the crucial factor necessary to establish a diagnosis or to estimate the progress or regression of a disease.

8. When a medico-legal situation exists, the radiologist has a right to refuse to release films necessary for his own protection, except when a court orders him to do so.

9. A liberal attitude regarding the release of films is more desirable than strict insistence on one's legal rights. It is better to run the occasional risk of losing films than to incur the enmity of a patient or of a physician by strict adherence to the rule (which, in the past, has led to attempts to pass laws making films the legal property of the patient).

10. In recognition of the universal importance of radiologic methods of examination, the principles regarding the use of roentgenograms outlined above are deemed by the American College of Radiology to be equally applicable to roentgenograms made by physicians other than specialists in radiology.

"WE'RE TESTING THE NEW SERUM ON HUMANS TO SEE HOW IT WOULD WORK ON GUINEA PIGS!"

THE sharp seasonal rise in pruritic affections during the warm months is due to a number of factors. Increased perspiration and tissue maceration, contact with allergenic plants such as ivy and oak, ingestion of heat-spoiled food and subsequent intoxication, all contribute their share. In the treatment of these affections, relief of the associated severe itching must be quickly accomplished. For this purpose, Calmitol enjoys a unique position. It stops itching promptly and for prolonged periods, regardless of cause. It enhances the efficacy of other indicated therapy, since it quickly restores emotional quiet and alleviates the need for scratching, thus preventing secondary traumatic lesions. Calmitol provides specific antipruritic action in ivy and other plant poisonings, urticaria, eczema, dermatitis medicamentosa, ringworm, prurigo and intertrigo, and pruritus ani, vulvae, scroti, and senilis.

Calmitol stops itching by minimizing transmission of offending impulses from cutaneous receptors and end-organs. Bland and nonirritating, the ointment can safely be applied to any skin or mucous surface. Active ingredients: camphorated chloral, menthol, and hyoscyamine oleate. Calmitol Liquid, prepared with an alcohol-chloroform-ether vehicle, is used only on unbroken skin.

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Enrollment Drive Planned for AMA Prepayment Program

Council on Medical Service reports on progress and the job ahead

Confident that medical societies will, by the year's end, have established prepayment plans in at least forty-three states, Dr. Edward J. McCormick, chairman of the AMA Council on Medical Service and Public Relations was able to report a month ago that:

¶ Thirty-one states had prepayment plans in operation or about to go into operation.[1]

¶ Seventy-three[2] plans were functioning in the thirty-one states.

¶ Thirty-four plans were affiliated with the Blue Cross.

¶ Twenty-three states had only one plan, generally state-wide; four had two each; three had three each; one had five; and one had six.

¶ Four plans reported enrollment of more than 200,000: Michigan Medical Service, 858,235; Washington plans, 250,000; Massachusetts Medical Service, 206,729; California Physicians Service, 202,000.

¶ Ten plans had been established in 1945, while ten had been set up in the first four months of 1946 and nine more were being organized.

¶ The following plans had been tentatively approved (prior to formal acceptance) by the Council on Medical Service and Public Relations: California Physicians Service; Iowa Medical Service; Michigan Medical Service; Ohio Medical Indemnity; Oregon Physicians Service; Medical Service Association of Pennsylvania; Medical-Surgical Plan of New Jersey; Nebraska Surgical Plan; and Surgical Care, Inc., Kansas City, Mo.

Commented the council: "A year ago the biggest problem was stimulating state and county medical societies to organize plans. With thirty-one states now having plans and more forming them, the big problem is to devise ways and means for increasing enrollment."

States with notable enrollment records (*e.g.*, Michigan, Massachusetts) also had acquired invaluable experience in promotional work. How that knowledge would be utilized and whence would come the large sums needed to finance it were problems that awaited the policy meeting of the Council on Medical Service and Public Relations and the convention of the American Medical Association in San Francisco early this month. —A. G. ROSS

[1] Ala., Calif., Colo., Conn., Del., Fla., Ind., Iowa, Kan., La., Mass., Mich., Mo., Mont., Neb., N.J., N.H., N.M., N.Y., N.C., N.D., Ohio, Okla., Ore., Pa., Tex., Utah, Va., Wash., W.Va., Wis.

[2] Fifty-one if Oregon and Washington, whose network of plans are sponsored on the county society level, were counted as having one each.

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Privine Hydrochloride acts quickly on the nasal mucosa without retarding ciliary activity. The solution is buffered to a pH of 6.2, closely simulating normal nasal secretions.

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PRIVINE is available in two solutions, 0.1 per cent and 0.05 per cent, packaged in 1-ounce bottle with dropper designed to dispense but three drops —the recommended dose. Also available in bottles of 16 fluid ounces.

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Insurance Questions and Answers

An insurance specialist tells you what your policies are worth

Q. What is savings bank life insurance?

A. It is a form of coverage created by law in a relatively few states. Savings banks in those states are authorized to issue life insurance just as insurance companies do, but at somewhat cheaper rates and with somewhat more liberal conditions. Although the laws permitting the issuance of such policies vary slightly in different states, $1,000 is generally the limit of the amount any one bank can issue for an individual applicant, with $3,000 as the maximum on one life for all banks. However, Massachusetts banks may issue policies for a total of about $25,000 covering one risk.

Q. A patient of advanced years and poor health has owed me $1,000 for professional services for several years. He has a life insurance policy, among others, for $1,000 on which he offers to name me as beneficiary. Would acceptance of this proposal assure payment to me at his death?

A. Simply naming you as beneficiary would not assure satisfaction of your bill at his death, because subsequent to naming you beneficiary, he could substitute another beneficiary without your knowledge. Furthermore he could lapse or surrender the policy without your consent. The safest procedure to follow would be to have him make an *absolute* assignment of the contract to you. By so doing he would forfeit all rights, title, and interest. He could not change the beneficiary or surrender it for cash. Also, if he failed to pay the premiums, you would have the right to do so, thus assuring continuance of the contract. In addition to the assignment, a promissory note from him might further support your claim to the proceeds of the policy at his death.

Q. How can I insure my instruments against theft while making calls?

A. A so-called professional instrument floater offers adequate protection. This policy covers all losses except depreciation and all articles except those of a brittle nature. It can be obtained (1) under a blanket form requiring no itemized list of the property covered, or (2) under a form which specifically describes and evaluates each article to be insured. Some companies exclude liability if your property is stolen from an unlocked car.

Q. If I have a fire which results in damage to my office or home, will my fire insurance policy continue to give me the same protection after

the loss has been paid?

A. No. Your protection is reduced by the amount of indemnity paid. You can, however, reinstate the contract for its original sum by paying a *pro rata* premium.

Q. My office is in my home. Can I insure myself against loss of income during repairs if a fire should destroy my house?

A. Yes. Protection against fixed overhead expenses and against loss of fees is available under so-called business and interruption insurance. This is a special type of policy which, in the event of fire, pays the insured an amount of money equal to a predetermined rate of earnings for as long as the insured is unable to conduct all or part of his practice. This policy also pays certain fixed expenses such as nurse's salary and will reimburse you for any period up to twelve months from the date of loss, or until the damaged office has been rebuilt and put into operation again.

Q. I often have appreciable amounts of money in the office. Is this covered under an ordinary theft policy?

A. No, an ordinary burglary and theft policy offers protection only up to $100. You can be covered, however, by a broad form money and securities policy which will protect any amount of money from loss by theft or fire.

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Dosage: Proloid is used wherever thyroid is indicated, in the same dosage as U.S.P. thyroid. In ¼, scored 1 and scored 5 grain tablets.

[1] Harrington, C. R.: "The Thyroid Gland," Oxford, 1933, p. 141.
[2] Meyer, A. E., and Wertz, A.: Endocrinology 24: 806, 1939.

PROLOID the improved thyroid

The Maltine Company NEW YORK 22

Individual Morally Responsible for Own Care, says Jesuit

Likens AMA's national program to Sinai's Ten Commandments

The American Medical Association has withstood the buffetings and jeers of American totalitarians because it would not yield the point that medicine is something different—not carpentry or smithing, but a personal service rendered by an individual to an individual.

Challenged with caricatures of the truth, the association has been accused of being a huge trust; of thinking in terms of its own infallibility; of opposing governmentally controlled medicine because it wishes to safeguard the physician's right to charge what he pleases. "If you don't like governmental programs, why not announce a program of your own?" the challenges have run.

Now the association has accepted the challenge. Its national health program, like the Commandments of Sinai, numbers ten indispensable "musts." And just as the Commandments, which Christ Himself has shown are reducible to two basic principles (the love of God and the love of one's neighbor as one's self), so too are the ten elements in the AMA program reducible to fundamental principles.

The association's program rests first and foremost on the principle of individual responsibility. Next to his soul, health is one of man's most treasured possessions, and it is incumbent upon him to maintain it. Moreover, each individual is responsible for the health of his dependents. This combined responsibility is a fundamental ethical one which no amount of explanation or subterfuge can remove. No self-respecting person able to assume the responsibility will attempt to shift it from his own shoulders to the shoulders of government.

As an individual, I must also safeguard society against any hazards implied in my disregard of health. In fact, I am bound in conscience to do so; and this, for a Catholic, means obligation under pain of mortal sin (which is pun-

▶ The author, Father Alphonse M. Schwitalla, is dean of the St. Louis University School of Medicine and president of the Catholic Hospital Association of the United States and Canada. The article is a condensation of a recent address before the National Physicians Committee.

ishable with eternal hell fire). I cannot grant that it is either society's or government's responsibility to safeguard my health, except in a very limited way (explained later).

Projected Federal legislation seeks all too facilely and too obviously to shift my responsibility to the shoulders of a government agent. It would substitute routinized, formalized, fractionized service under contract for service sublimely motivated and personalized to fit my needs.

The second principle of the AMA program requires the individual to call upon society's resources—when necessary—to assist him in carrying his basic responsibility. This does not mean that society is to relieve the individual of his obligation; it means only temporary assistance in specific circumstances. Maintenance of personal health in the face of epidemics, of housing shortages, or of a difficult or resistant disease may be beyond an individual's capacity, and he must be free in such cases to turn to society for such aid as it can provide.

The third principle of the AMA program is that government is society's agent in assisting the individual. Here, government has an enormous responsibility. It must see to it that needed aids are freely available—but in such a way that individual obligation is safeguarded. Public health and preventive medicine are aids—not substitutes—for the individual's moral obligations; and government must not acquire *domination* over any area of social significance. In the projected

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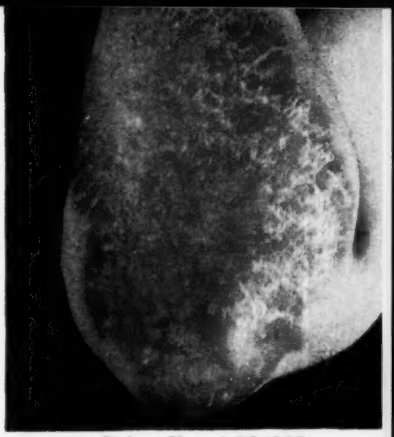

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PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	1.50 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.81 mg.
CALCIUM	1.12 Gm.	VITAMIN C	39.6 mg.
PHOSPHORUS	0.939 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.

legislation, any semblance of compulsion must be regarded as a distortion of basic responsibilities—and, therefore, immoral.

In any reasonable analysis of government's place in the life of mankind, government must always be kept keenly aware of its limited responsibilities. We all accept, theoretically or practically, the great truth that man's free will and his obligation of self-determination can never be destroyed by an agency outside the individual. Freedom of choice may be inhibited, but the power of choice must remain as long as man is rational. It follows, then, that government must remain the servant of the people; never can the people ethically become the servant of government (*vox populi suprema lex esto*).

So we come to the fourth basic principle: the method by which the individual may assume his responsibility. Since compulsion is indefensible, the national health plan must provide a complete freedom of choice; the individual must remain free to choose his physician, his hospital, his nurse. Without laboring the point in American history, we have committeed ourselves to a theory of private enterprise, of voluntary initiative and free competition; we have dedicated our nation to the concept of personal self-realization—within the limits of what we Americans call "fair play."

A fifth principle which finds expression among the AMA's ten "musts" requires preliminary explanation. Since there are gradations in government—local, state, Federal—that which is nearest to the individual is theoretically best able to understand and to meet his needs for assistance. Only local government, therefore, has the presumptive right and privilege to approach the individual; the Federal Government, in our theory of democracy, has no direct relationship with him; its relationship is indirect—through the state government; and the latter's, in turn, is through the local government.

It would seem to follow, then, that a prospective Federal law which lays claim to favoring the personal relationship between patient and physician, yet invades that relationship through direct legislation, is guilty of self-contradiction; such a law condemns itself by its own procedure.

Reducing these concepts to a principle, we may say that government, to be truly democratic, must be government from below upward—not from above downward.

So, out of five principles have grown the elements of the AMA program. To sum up: (1) The individual's right and obligation to be responsible for his health and that of his dependents must be recognized; (2) he must be free to call upon society's aid if he needs it; (3) government must provide him—but only to the necessary extent—with such assistance as he may need; (4) he must retain his liberty of choice in using the facilities provided for his assistance; and (5) only when local government feels itself inadequate to cope with the problem should the state intervene—and the Federal Government only when the state cannot do so.

—ALPHONSE M. SCHWITALLA, S.J.

Public Not Stirred to Take Sides In Health Insurance Debate

Average man favors medical insurance, but doesn't know who should administer it

Although public health insurance has been the subject of bitter controversy among medical groups and in Congress, the public's opinion on how the program should be carried out has not crystallized very definitely as yet.

According to a poll conducted by the American Institute of Public Opinion, the great majority of people think the idea of having insurance to take care of medical, dental, and hospital bills is a good one. But the public does not seem to have made up its mind how to pay for such expenses under such a plan.

Some people suggest private, voluntary programs; others, some kind of government program, such as is proposed in the Wagner-Murray-Dingell bill; while still others prefer private or community charity.

The poll likewise brings out these facts about public attitudes concerning the health program:

1. The general public has not yet become familiar with the Wagner-Murray-Dingell bill. Fewer than four in every ten persons polled said they had heard or read about it. As the discussion about the bill continues, this situation may change.

2. The typical American family estimates that it spent about $50 last year to cover all doctor, dental, and hospital bills.

3. The majority say they would not be willing to pay any more for medical insurance than they now pay in doctor and hospital bills, and about half say they would not be willing to pay as much. The median average of what people at this time say they would be willing to pay for a health insurance program, including doctor, dental, and hospital, is $30 a year.

4. Opinion is almost evenly divided on whether people would get better medical care than they are now getting if the government took over the job of administering a health insurance program.

One indication of uncrystallized public opinion on the issue of health insurance can be seen from replies to the question:

"What do you think should be done, if anything, to provide for the payment of doctor, dental, and hospital bills for the American people?"

The replies show a wide variety of ideas. A total of 17 per cent sug-

► The author, Dr. George Gallup, is director of the American Institute of Public Opinion.

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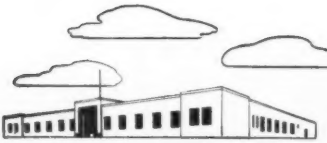
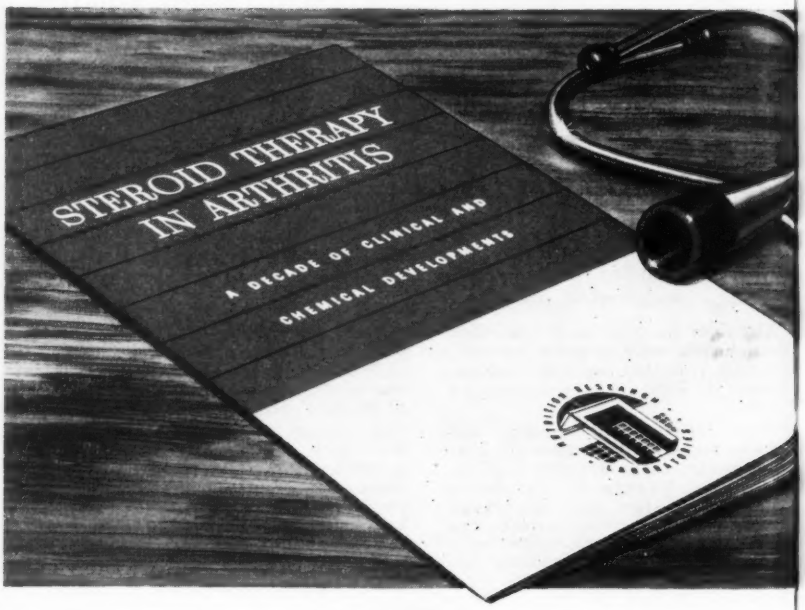


a decade



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gest voluntary health insurance programs, such as the Blue Cross hospitalization plan; another group, comprising 12 per cent, propose medical insurance under social security; a third group of about equal size (11 per cent) suggest special grants for hospitals and clinics to care for the needy. Another group of 6 per cent propose private or community charity. And 12 per cent give miscellaneous suggestions. Of the remainder, 16 per cent say they don't know what should be done, and 26 per cent do not think anything should be done.

Other question follow:

"Have you heard or read about the Wagner-Murray-Dingell health insurance bill which would require weekly pay deductions from every worker and employer for medical, dental, and hospital insurance?"

Yes	37%
No	63

People with a college education are the best informed; 66 per cent said they had heard of the bill.

	Had Heard	Had Not
College	66%	34%
High school	43	57
Grammar or no school	26	74

"Just making a guess, about how much did you pay for doctor, hospital, and dental bills during the past year?"

Nothing	16%
Under $25	21
$25 to $50	16
$50-$100	16
Over $100	28
Don't know	3
Median	$50

"How much would you be willing to pay a year for you and your dependents to join a health insurance plan which would pay all doctor, hospital, and dental bills?"

Nothing	9%
Under $25	30
$25 to $50	23
$50-$100	15
Over $100	4
Don't know	19
Median	$30

"If the government handled a health insurance program do you think you would get better medical care or not as good medical care as you are now getting?"

Better	32%
Same	23
Not as good	35
No opinion	10

—GEORGE GALLUP

Parlay

A Broadway gambler, well known in New York night life, was referred to me for an examination of his "ticker." After the consultation he asked the amount of the fee and counted it out from a thick bankroll. On top of it he put an extra $5. "There, Doc," he said grandiloquently. "That's for yourself." —M.D., NEW YORK

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THE Bayer Laboratories at Rensselaer, N. Y., have specialized in the production of Aspirin for over forty-seven years. Only the finest and purest ingredients are used in its manufacture. Every batch made is subjected to complete and rigid scientific controls. Seventy different tests and inspections have been developed to insure the quality, purity and uniformity of the finished product.

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and your favorite lengths and gauges are now available

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Made from genuine Stainless *Cutlery* Steel, the VIM point is beautifully tapered and hollow-ground; the flat edges of the point are razor-sharp and thus gently slit tissue and vein wall instead of puncturing. Most important, VIM points hold their sharpness despite continued use and sterilization; they are heat-treated and uniformly tempered to exactly the hardness required to assure long-lasting service in a cutting instrument. If it's a VIM, it stays sharp longer.

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22 Gauge, ¾" 1" 1¼" 1½"	

Order these sizes from your surgical instrument dealer. Write us for a complete list of sizes for general Hypo use, for Intramuscular, Intradermal, Subcutaneous and Immunization work.

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CANADA—Ingraham E. Bell, Ltd., Toronto, Montreal, Winnipeg, Calgary
GREAT BRITAIN—Henry Milward & Sons, Redd'tch, England
SOUTH AMERICA—G-E Medical Products Co., Chicago, Illinois

Doctors Defeat Antivivisectionists

Vigorous campaign convinces press, public, and legislators that science is right

"To win any battle in a legislature you've got to do two things," says Dwight Anderson, public relations director for the Medical Society of the State of New York. "You have to convince the legislators that you're right. You also have to convince them that a majority of their constituents think you're right."

In its successful battle against an antivivisection bill in the New York State legislature early this year, the New York medical society did exactly that. Its well-organized campaign, based on Mr. Anderson's two "musts," defeated the hysterical efforts of antivivisection groups, led by the Hearst press, to pressure legislators into passing a bill outlawing the use of dogs in medical research. Its campaign also set a pattern for effective medical-society public relations which other societies might do well to study.

"Perhaps the thing that ought to be emphasized about our campaign," says Yolande Lyon, Mr. Anderson's associate, "is that we were ready for action. We suspected that an antivivisection bill was coming up, and we began to make our preparations in June 1945. We visited research agencies to get information on the contributions made to medical science by research with dogs. After that we began to assemble material for a speakers' handbook and mass distribution leaflets. When the fight finally broke we were ready."

The campaign against the antivivisection bill in New York was actually carried on through the Friends of Medical Research, an organization set up for that purpose by the New York State Medical Society with the cooperation of the New York Academy of Medicine. The advantage of a separate organization was that it enabled the medical profession to draw into the campaign important public figures. Among FMR's initial sponsors, for example, were such men as Nicholas Murray Butler, president emeritus of Columbia University; Fiorello H. LaGuardia, former mayor of New York; Gerard Swope, former president of the General Electric Company; John W. Davis, former ambassador to Great Britain; and Clif-

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▶ This is the second of two articles on the sensational national campaign to force enactment of antivivisection laws. The first, which appeared last month, detailed the role played by the Hearst press in arousing hysteria among dog lovers.

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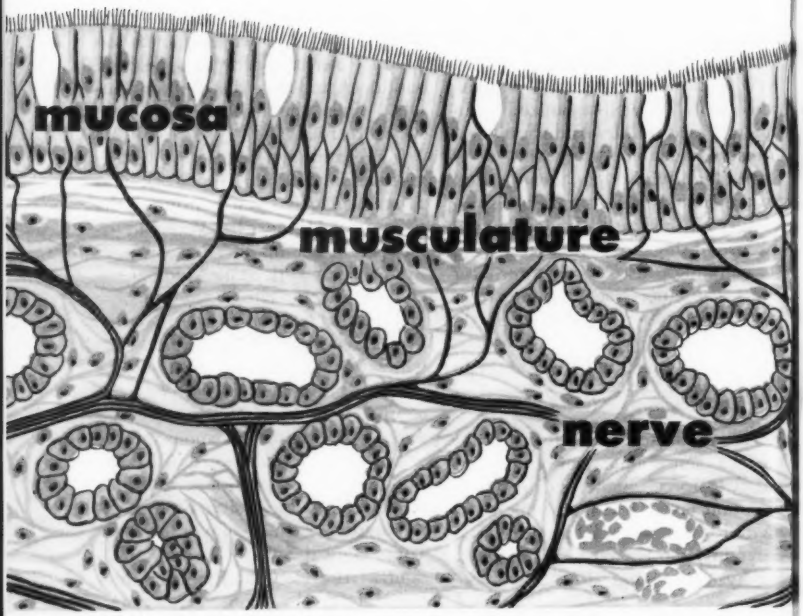
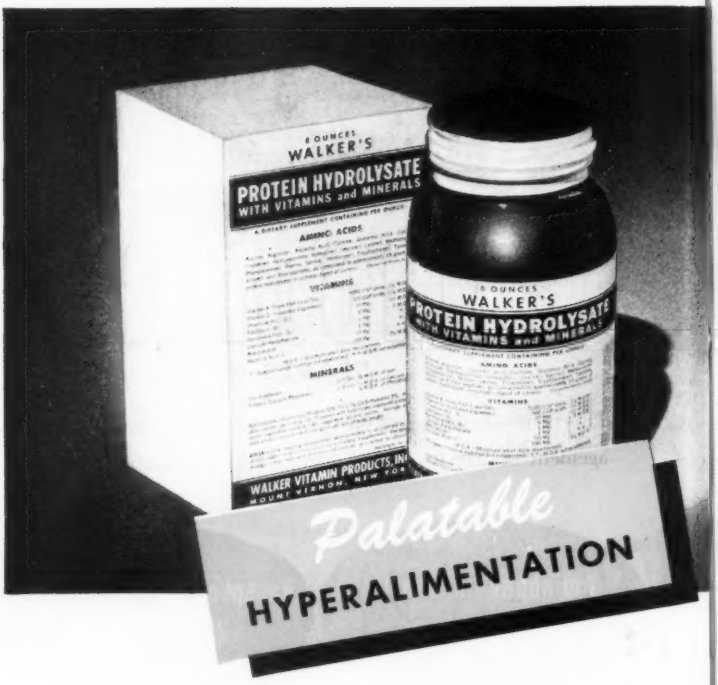
respiratory mucous membrane . . .
bronchiolar musculature . . .
central nervous system . . .

All three are involved in the pathologic physiology of allergic manifestations of the respiratory tree.





There's growing emphasis on hyperalimentation as an adjunct to therapy. WALKER'S PROTEIN HYDROLYSATE WITH VITAMINS AND MINERALS has the pleasant savor of fine bouillon assuring patient acceptance when prescribed in: Pre- and postoperative dietary therapy, peptic ulcer and certain other gastrointestinal diseases, nutritional edema and anemia, pregnancy and lactation, febrile disease, periods of active growth and aging, and wherever protein hydrolysate-vitamin supplementation is indicated. Available through prescription pharmacies. Professional literature on request.

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Walker VITAMIN PRODUCTS, INC.

MOUNT VERNON, NEW YORK

ton Fadiman, author and critic.

FMR's activities, which were run mainly by the New York State Medical Society, centered around three linked points: (1) obtaining favorable newspaper publicity; (2) educating the public to the dangers of antivivisection measures and inducing them to communicate with their legislators and (3) educating the legislators themselves.

FMR's imposing list of sponsors and the fact that it was able to place in the hands of editors a clear, authoritative, and detailed case for the continued use of dogs in medical research enabled it to swing almost every newspaper in the state, with the notable exception of the Hearst press, behind its campaign to defeat antivivisection. The nearly unbroken newspaper front, which was reflected in wide coverage of FMR activities and strong editorial support, served two purposes: It more than counter-balanced the Hearst pressure on legislators and it helped to organize public backing.

Typical of the newspaper support received by FMR was an editorial in the Buffalo Courier Express. Headed "Saving Human Lives," it cited a number of instances in which medical research with dogs had contributed to medical progress and the public welfare. Quoting from Dr. George Baehr, president of the New York Academy of Medicine, it said that the results of an antivivisection bill on medical progress would be "catastrophic." Had such a bill become law in the past, added Dr. Baehr, "it would have been impossible to develop insulin, which is responsible for keeping alive more than a million persons in the U.S."

The educational work done through the newspapers was important, but it merely supplemented FMR's direct appeal to New York communities. Local medical societies were encouraged to create groups similar to FMR in their own communities, and to distribute material containing arguments against the antivivisection bill to voters.

One educational folder, on the face of which appeared the picture of a lusty infant, was entitled "His Future is Brighter—Thanks to Medical Research." It concluded with a forceful statement by Howard W. Haggard, director of Yale University's Laboratory of Applied Physiology, aimed at "saboteurs" of science. "In the grim war against disease," it said, "their ignorance and bias may threaten more lives than those lost on the battlefields of all national wars."

Another piece of literature distributed was a "Voter's Ballot." This

Double Talk

Years ago, one of our salesmen called at the home of a country doctor. The hired girl met him at the front door and the following conversation took place: "Is the doctor in?" "No." "That's too bad." "Why?" "I have a sphygmomanometer under my arm." "Does it hurt much?" "No, but I'd like to get rid of it."

—WILLIAM A. BAUM JR.

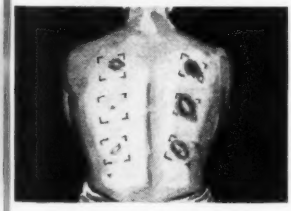
was a card addressed "Dear Legislator" on which voters told their representatives that "A vote against this [antivivisection] bill is a vote in favor of future medical progress." One legislator revealed that he had received 800 such cards in a single week.

"The antivivisection groups obtained hundreds of thousands of names on petitions," says Mr. Anderson. "But petitions aren't as effective as some people think. They don't tell individual legislators how their constituents, specifically, feel about a bill. Our cards, which carried the address of the writer, did tell them. And, judging by the results, they told them effectively."

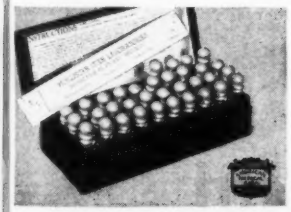
While the antivivisection bill was pending before the legislature, FMR directed a continuous flow of information to individual legislators. This information fell into three categories: refutation of false claims made by the antivivisectionists and by newspapers; general information on the value of animals in medical research; and clippings from newspapers throughout the state reflecting opposition to the antivivisection bill.

When Hearst's Journal-American made the claim, for example, that Dr. Edward S. Godfrey, commissioner of the State Department of Health, opposed the use of dogs in medical research and Dr. Godfrey indignantly denied the report, both statements were reproduced in a folder, entitled "The Ananias Prize Award for 1946," and sent to every member of the legislature. "We watched the newspapers very closely," says Miss Lyon, "and any misleading statement in antivivisection

Hyposensitization by injection



Negative and Positive Reactions



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For over 25 years, thousands of physicians have hailed Hollister-Stier's unsurpassed service, facilitated by strategically located laboratories—manned by highly competent technical staffs. On exceedingly short notice, Hollister-Stier provide individually prepared materials for desensitization of unusual allergies—as well as extracts from their highly diversified line of over 200 pollen allergens (personalized as to patient's locality and season)... nearly 400 protein extracts... autogenous extracts... and rhus prophylactic and treatment sets. • Hollister-Stier extracts are Council-accepted, Government-licensed. They are true glycerine-saline extracts—always fresh, potent, stable and inexpensive; standardized on the weight-by-volume principle, and packaged in bulk vials. Use coupon to request free copy of 36 page brochure "Important Facts about Allergy".

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Please send me free copy of 36 page brochure "Important Facts about Allergy".

DR._____
Please Print Clearly

ADDRESS_____

CITY_____ STATE_____

propaganda was sent on to the legislators."

Since the antivivisectionists were exploiting the sentimental attachment most people have for dogs, the New York State Medical Society devoted part of its effort to channeling this sentiment behind its own campaign. It inaugurated a Whipple Prize, named after Dr. G. H. Whipple of the University of Rochester, "In Tribute to Dogs for Outstanding Services to Humanity." The prize was awarded to two research dogs, "Josie" and "Trixie," whose ancestors Dr. Whipple had used in investigations which led to the liver treatment for pernicious anemia.

"I guess we covered just about every angle," says Miss Lyon. "In a sense, the antivivisection campaign was a blessing. It gave us a reason for doing a much needed educational job. Probably the beneficial results of that educational job will last a long time."

The Friends of Medical Research, though organized specifically for the New York campaign, will be continued on a national basis under the sponsorship of the National Society for Medical Research which was formed this Spring by the Association of American Medical Colleges. Dr. A. J. Carlson is chairman and Dr. A. C. Ivy is secretary-treasurer. The address of the organization is 303 East Chicago Avenue, Chicago, Ill.

"Working together," Mr. Anderson points out, "these two organizations will be ready to fight the antivivisectionists effectively whenever and wherever they start a new drive to impose their prejudices on the public."

—PAUL STEVENS

PECTIN for detoxification — **KAOLIN** for adsorption — **MALT** extract for energy and flavor — ***PEKTAMALT*** is usually the only medication needed for speedy control of diarrhea, dysentery and colitis. *Its high pectin content — 10 grs. per fluidounce — provides an effective dosage.*

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Pektamalt is safe, reliable — prescribe it as your basic medication for diarrhea, dysentery, colitis.

Each fluidounce of Pektamalt contains:

Pectin	10 grs.
Kaolin	100 grs.
Alcohol	7 %

In a malt-flavored base

Supplied in 10 oz. and 4 oz. bottles

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NOAH WEBSTER, THE DOCTOR and THE DETAIL MAN . . .

TO Noah Webster, the Detail Man is *"one who relates in particulars, reports minutely and distinctly, enumerates, specifies, itemizes,*—as, he *detailed* all the facts in due order."

To you, a doctor, the Detail Man is all of the above and should mean a great deal more to you and your practice.

The Detail Man's *purpose* is to serve you in every way he can—to keep you informed of "all the facts in due order" about the field he represents—to report to you on wartime developments and the latest research and clinical findings.

He calls on you to describe his products "minutely, distinctly" and accurately—and in as few words as possible.

His story may take only a few minutes or it may take longer—depending entirely upon the amount of "news" of his field that he has to report to you and how busy you are at the time of his call.

So leave the welcome mat out, doctor. Let the next Detail Man have a few minutes of your time.

A Good Detail Man is a Specialist . . . in Service

Positions Wanted by Physician-Veterans

Any physician returning to civil life from the armed services or from a war agency may insert *free* in MEDICAL ECONOMICS (circulation: more than 100,000) a position-wanted ad of up to 24 words. The following data, which will be kept confidential, must accompany ad copy: name, address, rank or position, date. Copy must reach MEDICAL ECONOMICS before the 5th of the month preceding publication. Address: Veterans' Editor, Medical Economics, Inc., Rutherford, N.J.

ASSISTANTSHIP in obstetrics-gynecology desired; Phila. area; eligible for board; now in Pa. Box 1641.

GENERAL PRACTICE assistantship or association desired in Atlantic City or vicinity; age 30; licensed in N.J. and Pa.; Box 1647.

GENERAL PRACTICE; position desired in southern California; age 26; approved school; internship served in the U.S. Navy; Calif. license; now in Calif. Box 1644.

LOCATION desired; group practice, assistantship, partnership, or take over practice; excellent education; 5 years' postgraduate hospital training; interested in dermatology; now in N.Y. Box 1646.

PARTNERSHIP desired; age 28; 18 months' interneship, 8 months' industrial practice; service with general hospital; Ky. and Fla. license; now in Ky. Box 1640.

PHYSICIAN; age 35; industrial experience; desires part or full-time position; also consider preparation of medical literature for advertising; kindly state salary; now in N.J. Box 1642.

SURGEON, 33, well-trained in general and industrial surgery, desires assistantship to American board surgeon for purpose of completing requirements; needs 1-1½ years; New England location only; now in Mass. Box 1648.

TUBERCULOSIS specialist desires superintendency or association with well-qualified doctor; 12 years' experience in tuberculosis centers; eligible for board; now in Calif. Box 1643.

At first the infant,
Mewling and puking in the nurse's arms*

ZYMENOL has long been recognized by obstetricians and pediatricians as an ideal bowel management therapy.

ZymenoL, a brewers' yeast emulsion,** aids restoration of physiological bowel content through zymolysis and helps to normalize intestinal motility with its complete, natural vitamin B complex content.

Soft, comfortable, regular evacuation is assured without catharsis or colloidal bulkage. Because ZymenoL is agreeably palatable, sugar free, and the only emulsion effective in *teaspoon* doses, patient-control is seldom a problem.

For patient-acceptable bowel management in *any* age group—specify ZymenoL.
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Brewers' Yeast Emulsion
Effective in

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Here is the fourth in a series of Ry-Krisp advertisements designed to be of real help to doctors. This Ry-Krisp advertising points out the dangers of obesity, urges overweight people to consult their physician.

We hope it will help you to help more of your overweight patients.

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Low-Calorie Diet Booklet with 1200-calorie diet for women, 1800 for men; menus, recipes; space for patient's name, your signature; pocket-size. For doctors only. Also, revised Allergy Diets—up-to-the-minute information for egg, wheat, milk-free diets.

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Please send, no cost or obligation, material checked below.

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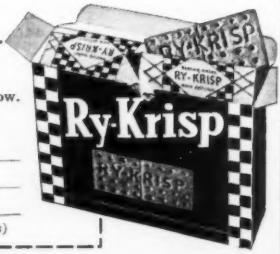
(Offer limited to residents of Continental United States)



RALSTON PURINA COMPANY, Checkerboard Square, St. Louis, Missouri

The Consequences of S.1606

History of Bismarck's political health plan is seen as warning to U.S.

The Wagner-Murray-Dingell bill of 1945 and the earlier version of 1943 find their prototype in the insurance laws of Bismarck. During the 1880's Bismarck, acting on the recommendations of his economic adviser, Adolph Wagner, professor of political science at the University of Berlin, laid down the general principles of social insurance. Laws of sickness insurance, accident insurance, and old age insurance were enacted despite bitter opposition. Bertrand Russell has said that Bismarck's aim was, "first to muzzle the official Social Democrats, and then, by a series of small bribes, to wean the proletariat from their adherence to revolutionary principles."

Bismarck translated into law the theories of the man who is credited with having done more than anyone else to give to state socialism its "scientific form and scientific foundation." Professor Wagner's social philosophy and total program for state control were outlined in an article published in 1887 in which

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▶ Marjorie Shearon, PH.D., the author of the accompanying article, is one of the nation's top authorities on social security. Her volume, "Economic Insecurity in Old Age," prepared for the Social Security Board, was used as a brief by Justice Robert H. Jackson when he defended the constitutionality of the Social Security Act before the Supreme Court. In reading the majority decision upholding the act, Justice Benjamin Cardozo quoted extensively from the volume. ¶ After engaging in public administration and research for many years, Mrs. Shearon joined the staff of the Social Security Board in 1936. She resigned in 1941, "having come to the conclusion that compulsory sickness insurance legislation was being prepared by the board not as a health measure but for the purpose of centralizing great power and funds in a single, non-health agency." Mrs. Shearon is presently research analyst for the Conference of the Minority, U.S. Senate. The accompanying material was prepared for the National Industrial Conference Board and is published by special arrangement with that board and the author.

he advocated public ownership of banking, insurance, communications, and utilities, and state "insurance against sickness, incapacity, and old age." He likewise proposed a new scheme of taxation that would not only serve the legitimate purpose of raising revenues but would at the same time constitute what he called "regulative interference."

This "interference" was to operate by regulating first the distribution of income and wealth and second the purchasing power and living habits of the "lower classes." The latter form of "interference" was to be accomplished "by administrative measures, and eventually by compulsion." Wagner stated: "This two-sided policy of taxation I call social. The second side here advanced . . . is based, as concerns the mass of the population, the lower laboring classes, on the assumption that in the truest interests of the nation a guardianship may and must be exercised over the national consumption or over the application of income to personal purposes."

His "social" insurance laws, thrown as a sop to the socialist Cerberus, were acclaimed as "the high-water mark of German State Socialism." Designed to quiet the complaints of the socialists and at the same time to ease the burden on the local governments for care of the sick poor, they were political and economic devices rather than health measures. The law of sickness insurance was passed without the professional advice of health and medical experts and physicians, and administrative control was placed in lay hands. Bismarck, it is to be remembered, was hard-pressed for funds. He was seeking new sources of revenue. In the guise of what he called "practical Christianity," he induced the Reichstag to approve his new plan for taxing the workers, thereby making them shoulder the burden of most of their own poor relief. In return for their acceptance of the principle of "compulsion" and of control by a powerful bureaucracy, the "lower classes" were promised pitifully small and limited benefits.

German sickness insurance was financed by taxes on employers and employes, the latter (until as late as 1934) paying two-thirds of the cost. The Government provided the compulsion and interference; labor and management footed the bills. The doctors were squeezed between the upper and nether millstones of regulation and interference. Benefits were of two kinds: a cash sickness benefit equal to not less than one-half the daily wage, and free medical and hospital care during illness. Minimum benefits were for twenty-six weeks with optional extension to fifty-two weeks if funds were available. Small maternity benefits and death benefits were also provided. Originally coverage was limited to

Answers to Quiz

(See page 47)

1c. 2b. 3b. 4a. 5c. 6a. 7b. 8b.

low-paid workers in a few occupations; ultimately it was extended to all manual workers and all others with incomes not exceeding 3,600 reichsmarks annually, so that, with dependents, two-thirds of the population was covered. Under the law total "contributions," the euphemistic name given to the new taxes, could not exceed 7.5 per cent of earnings and usually were limited to 6 per cent. There was no state subsidy.

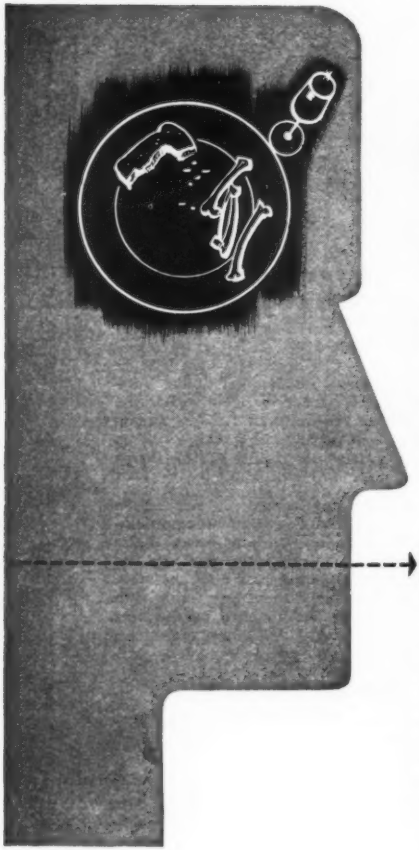
The Bismarck plan of social insurance has been adopted in over thirty countries, generally as a political, fiscal, and regulatory device. The schemes for compulsory sickness insurance have in the main followed the original pattern. While details vary from country to country, the distinctive characteristics of compulsion and "regulative interference" persist. Indeed, they are integral parts of the scheme and are, as many persons believe, the inherent cause of its weakness. Some countries have broader coverage, others more restricted. Great Britain insured only 40 per cent of the population, and excluded dependents of workers. Russia, on the other hand, covered the entire population and carried the compulsory scheme to its logical conclusion by making all physicians the salaried servants of the state. New Zealand attempted complete coverage and a mixed system of payment for physicians. Thus, the framework and essential structure of the compulsory insurance features of the W-M-D bills are neither new nor original. They are a composite of old-world statutes written in such a manner that they may be incorporated into a comprehensive system of Federally operated and controlled social insurance.

In considering the sickness insurance bills now pending before Congress it would seem to be advisable to investigate the efficacy of the Bismarck plan. How well has it worked in the sixty years of its operation? Has it been administratively satisfactory, politically desirable, and medically sound?

Some of the answers to these questions are to be found in an appraisal of the German system made by Isidore S. Falk, who is generally credited with being the leader of the movement to establish Federal compulsory sickness insurance in the United States. After studying the German and other European schemes he stated in 1936:

"Observers are in general agreement that the German sickness insurance laws and the central administration are very complex. For this there is a simple historical explanation and, perhaps we may say, justification. When first conceived, Bismarck contemplated a system which would absorb the existing insurance societies and provide for the formation of new ones. The state did not intend to contribute to the insurance benefits; the scheme was

[*Continued on page* 116]



Here's Food for Thought

Many people find food for thought *after* they have finished their meals. For too often overindulgence in eating, drinking and smoking starts them seeking prompt relief from nausea and stomach upset.

When such distress is due to gastric hyperacidity, BiSoDoL the effective antacid alkalizer can be depended on for quick, pleasant relief.

May we suggest you try BiSoDoL in your practice?

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The Case of the

TRANSPARENT HEART

"FIFTEEN MINUTES • • • that's all . . . sure they'll check . . . the gun . . . the fingerprints . . . the alibi • • • Blind alleys is all they'll find, tho • • • Yeah, it's neat and foolproof • • • WHY? . . . Because of FIFTEEN MINUTES . . . for who's goin' to tell within fifteen minutes when he died • • • and fifteen minutes is just enough time . . . for me"

Thus a criminal investigation may bog down because the time of death can not accurately be determined.

Death Is Measured

In bio-assay procedures the time of death of laboratory animals determines the relative potency of different lots of drug. But here again, the time of death is difficult to observe.

Research in the Irwin, Neisler laboratories has developed an assay procedure for Veratrum Viride wherein death is observed under the microscope. The test is run on Daphnia Magna, a small water crustacean bearing all the characteristics of the mammal and being transparent under the low power lens. Thus the trained observer can actually see the ***transparent heart*** and determine, within narrow limits, the time of death.

New control methods have been a constant goal of Irwin, Neisler. Only by using a bio-assayed Veratrum Viride, for example, can the physician be assured a known clinical action of this valuable drug in treatment of hypertension.

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to be a mutual undertaking between employers and employes which the state was to supervise and regulate. In consequence, the benefits would be only those which the contributions from these two classes could finance.

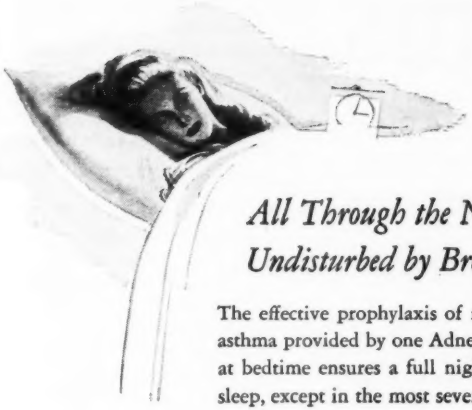
"The state wished to make benefits appear as attractive as possible; but it dared not promise more than the contributors could and would support. The laws were therefore framed on the principle of specifying the minimum benefits which must be furnished and the maximum contributions which may be required. The system had to be framed to cover widely differing conditions among urban and rural communities and to meet the needs of all industrial classes, from the most substantial down to the dependent poor. Flexibility was therefore essential, and *flexibility meant various, diverse, and complex legal provisions.*" (Italics mine.)

The author then goes on to point out that the insurance societies responsible for administration of sickness insurance funds had devoted too little money to public health activities, spending in some years as little as 5 or 6 cents a person for the improvement of health. It is further admitted that German insurance practitioners were underpaid and suffered from lay controls.

In the light of these facts one may wonder why the Federal official who saw all the defects of compulsory sickness insurance should have written into the successive Wagner-Murray-Dingell bills the very provisions which he admitted were provocative of discord and reasonably certain to lead to autocratic rule, red tape, and limitations on freedom. The mixed system of remuneration of physicians which he has proposed has bankrupted one sickness insurance scheme and might be expected to do the same thing in this country.

It is being loudly proclaimed at this time that Federal sickness insurance legislation should be enacted forthwith in order to induce physicians to leave the cities and settle in rural areas. But the scheme did not have that effect in Germany where after sixty years' operation it was observed that "the physicians of Germany are located in excessive proportions in the large cities and in inadequate proportions in rural areas." It has been stated repeatedly that the incomes of the majority of physicians would be improved under the provisions of the latest W-M-D bill. But insurance practice did not have that effect on the income of German physicians. In 1936, Mr. Falk stated:

"The inadequacy of professional income is even more discouraging in Germany than in the United States because it bears with unusual weight upon the insurance practitioners; whereas the less-than-average incomes of most physicians in the United States are 'compensated' by the greater-than-average in-



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comes of the others; in Germany the less-than-average incomes occur mainly among insurance practitioners whose clientele is among the poor, and the greater-than-average incomes occur chiefly among non-insurance practitioners who serve private patients in the higher income classes."

It is significant to note that following the National Socialist revolution in 1933 Hitler reorganized Germany's social insurance system. At that time, the government's medical program was looked upon by many as one of the greatest props of the totalarian state. The "leader" idea was introduced into the insurance system and Hitler issued a series of decrees in 1933, 1934, and 1935. "The new law, the decrees, and the regulations have profoundly changed the arrangements under which medical services are furnished. Where hitherto the contract of service had been left to each fund to be negotiated with each doctor, it is now a central contract governed by law and regulation," wrote Mr. Falk.

The two leading professional organizations of German doctors were dissolved. Hitler gave exclusive legal status to the sickness insurance doctors of Germany. This group was given authority by decree to furnish medical services to insured and uninsured persons and to decide on remuneration. It was given responsibility for the punishment of its members. In this connection, I would point out, as others have before me, that a comprehensive Government sickness insurance scheme with its nation-wide bureaucratic machinery lends itself to administrative abuses with peculiar ease when the central power passes to a sadistic leader of

"THE COOLE AND SILENT SHADES OF SLEEP"

—Robert Herrick: Hesperides, 1648

Suspense, anxiety, nervousness—those specters which haunt our days and which are aggravated by overwork—cannot always be banished when desired or supplanted by restful, recuperative sleep.

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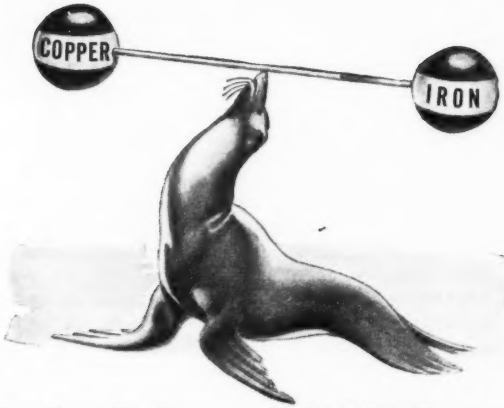
the Hitler type. Punishments are devised for physicians and patients; the rights of the individual are abrogated. This was done in Germany. It could be done here.

It is obviously impossible in this short statement to enter into an exhaustive discussion of the attributes of a compulsory sickness insurance program. I should, however, like to say a few words about the operation of the principle of "regulative interference." The claim is frequently made that compulsory sickness insurance does not change the practice of medicine. Patients, it is said, will be free to enter or to remain out of the system; physicians will enjoy similar freedom. Patients may freely choose their physicians from among those who have consented to become insurance practitioners and have signed a contract with the Federal Government to abide by the rules and regulations to be issued in Washington.

Is this freedom? Patients would have about as much freedom as a prisoner in a Federal penitentiary would have if given the choice of working on the rock pile or in the prison laundry. Physicians on their part would be expected to make a blind date with the official in Washington who would one day promulgate the insurance rules and regulations which would have the force of law.

And what about patients? Under the latest W-M-D bill, insured persons would be given the following degree of freedom: Once the law went into effect every insured person would be informed as to the doctors in his particular insurance district who had agreed to become insurance practitioners. If the panel or capitation system such as is used in Great Britain were adopted, there would be a limitation of say, 1,000 or 1,500 patients per physician. Insured persons would be given a certain period of time to sign upon some doctor's panel. If they failed to act they would, after due notice, be assigned to some doctor by the Surgeon General of the Public Health Service or his local representative. Clearly there would be a rush to get on the panels of those doctors who were considered to be the best in the community—assuming that they would consent to enter the system. Persons who delayed or were recalcitrant would have to take the less satisfactory doctors or would compulsorily be assigned to doctors whose lists had not filled rapidly. Persons moving into the neighborhood would have to be content with the left-overs. If it so happened in a small community that none of the doctors were particulary good, insured persons would still be compelled to sign up with them and could not make arrangements with better qualified doctors in adjoining communities, unless they did so at their own expense in addition to paying their increased social security taxes and income taxes. Under the panel system of insurance prac-



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tice the insured person becomes a pawn to be placed on panels at so much per head per year for the purpose of guaranteeing to physicians minimum incomes which tend in time to become maximum incomes.

Under the W-M-D bill specialists would be available, as a rule, only on the advice of the insurance doctor. Obviously there might be occasions when a patient would demand a specialist and the insurance practitioner in the interests of economy would refuse his consent. In such a case the patient would be compelled to refer his appeal for the services of specialists and consultants to the local medical administrative officer appointed by the Surgeon General. Anyone who has endeavored to obtain quick action on an appeal to a Government agency in connection, let us say, with an OPA regulation will appreciate that a critically ill patient would probably be dead before he could obtain a ruling on his "right" to specialist and consultant services.

This is what is meant by regimentation and regulation of patients—this, multiplied a thousandfold. It is claimed that under the W-M-D bills insured persons would receive "the best modern medical care." *The bill does not so promise.* Instead, it specifies cheap and limited services. It would, for instance, pay hospitals "not less than $3 and not more than $7 for each day of hospitalization, not in excess of thirty days." This implies ward service. Indeed, the language in the bill refers to payment for "essential hospital services, including the use of ward or other least expensive facilities compatible with the proper care

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of the patient." Always the emphasis is on economy, on the protection of the insurance funds rather than on the "best modern medical care" which is nowhere mentioned in the bill.

The claim is made that patients not only have freedom of choice of physicians but that they may change doctors if they are dissatisfied. Again, they have that brand of freedom that is permitted under Government dictatorship. If we may judge by the "freedom" accorded insured persons in other countries, it is perfectly clear that such limited freedom as will be enjoyed will obtain at the moment of entering the system. It does not mean freedom to pick the doctor you want at the time of sickness which may be months or years after the date of entry into the sickness scheme. In Great Britain, the patient seeking to change insurance doctors must obtain the written consent of the doctor who is being dropped and of the doctor whose services are sought. But the need for change generally arises as an emergency matter when minutes may mean the difference between life and death for the patient. Perhaps under the new dispensation death, before striking, will wait for an official O.K. from Washington.

We can presently be philosophical about Government red tape in connection with controls over industry, consumers goods, and prices. We look forward to the day when such controls will be removed. There is something grimly humorous about interminable forms in triplicate. One can even believe—albeit with difficulty—that one still has a court of last resort when one is told that if dissatisfied with the ruling of the administrator in a regional office, one may, within ninety days, appeal to the authorities in Washington by filing the appropriate official forms (seven copies, please). If one is still dissatisfied there is a modicum of comfort in knowing that one may finally appeal to the Supreme Court of the United States. This routine may have elements of humor when inanimate goods are concerned. There would be nothing humorous if a life were at stake. Nor can it be argued that analogies are far-fetched.

The degree of "regulative interference" with patients and physicians under the British and German sickness insurance schemes is unbelievable. Consider the provisions of the German Insurance Code with respect to hospital treatment. Economy of administration is the domi-

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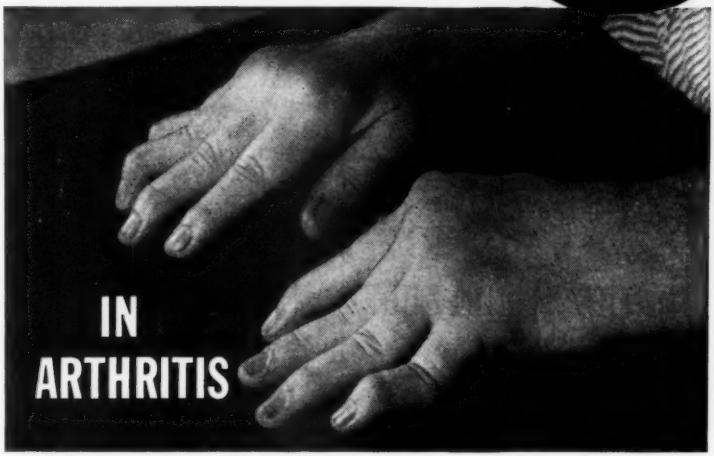

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nant note. Thus, when it appears to an insurance practitioner that a patient should be hospitalized the code specifies that "The attending practitioner must prove the necessity of hospital treatment in writing." Furthermore, the code and contract regulations specify that "The consent of the sickness fund must be obtained before admission to hospital except in urgent cases. The patient's consent is not required (1) if the nature of the illness is such that treatment and nursing cannot be given at the home of the patient; or (2) if the disease is infectious; or (3) if the patient repeatedly disregards the doctor's instruction or the rules for the conduct of patients." Is this regimentation?

The insurance system in Germany is policed by medical referees "in respect of the economy and the standards of medical treatment." Medical referee service centers are set up, there being one medical referee for every 25,000 insured persons. These medical referees, among their many duties, "are consulted, if required, before admission of patients to hospitals."

Doctors are under strict control with respect to the prescriptions they may write. "The standard cost of prescribing per case treated is fixed in the national agreement for the whole country." If on investigation by a medical referee it is decided that an insurance doctor has written prescriptions that are deemed too expensive or has prescribed costly new drugs without sufficient justification, the doctor may be penalized by having the excess amounts deducted from his government reimbursement. Such prohibitions ultimately lead to rigidity. [*Continued on page* 130]

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DISEASE	GOOD 84%	FAIR 6%	POOR 10%
Chronic Ulcerative Colitis	20 acute 54 chronic	1 acute 1 chronic	1 acute 3 chronic
Bacillary Dysentery		2 chronic	
Giardia Lamblia	2 acute 6 chronic		
Paratyphoid		2 chronic	
Dientameba Fragilis	2 acute		
Amebic Colitis			4 acute 2 chronic
Total Number of Patients 100	24 acute 60 chronic	1 acute 5 chronic	5 acute 5 chronic

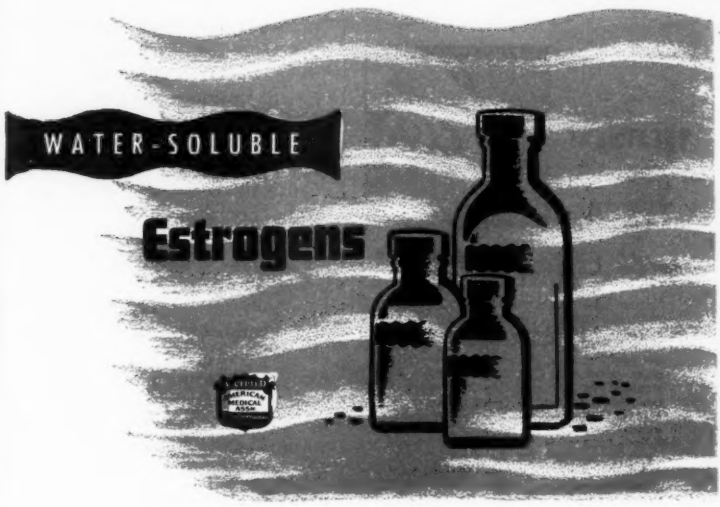
XUM

These are a few of the restrictions that hamper physicians under compulsory sickness insurance schemes. They are to be found in the rules and regulation in all countries having medical insurance benefits; such regulations are numbered by the thousand. This is what is meant by regimentation of doctors and patients. This is what lowers the quality of medical care and stifles initiative.

The International Labour Office has published an exhaustive volume entitled "Economical Administration of Health Insurance Benefits." The first part consists of 133 pages describing The Principle of Economy in Administration of Health Benefits; the second part consisting of 173 pages is devoted to The Principle of Economy in National Laws and Regulations. There are rules for the conduct of patients, rules for doctors, rules for hospitals, rules for prescribing, etc. The basic law, complex as it is, is but a very small part of the regulatory machinery of sickness insurance. Thus, in Great Britain the laws of national health insurance, the rules and regulations, and the interpretation thereof are set forth in a volume nearly 1300 pages long and every insurance practitioner has on his desk a volume of over 350 printed pages known as the "Doctor's Bible," which informs him as to what he may or may not do.

It is of the utmost importance to realize that the three Wagner-Murray-Dingell bills were not drafted along American lines but are in direct conformity with the international provisions which have been laid down by the International Labour Office; these in turn largely reflect the German viewpoint with respect to the nationalization of medicine and the concentration of power in central governments.

With reference to the two W-M-D bills, I wish especially to direct attention to the devices employed for the purpose of conferring vast power on the Social Security Board. First, there is created a National Social Insurance Trust Fund which is to be held by a board of trustees consisting of the Secretary of the Treasury, the Secretary of Labor, and the chairman of the Social Security Board. To this fund would be transferred all the present assets of the Federal Old-Age and Survivors Insurance Trust Fund. Into this fund there would pour all the new and greatly increased social security taxes—4 per cent of payrolls from employers and 4 per cent from employes, plus 5 per cent of the income



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(up to $3,600) of self-employed persons, and such other tax receipts as might be paid in the form of premiums for insurance for the state employes and statutory beneficiaries, plus, finally the Government subsidy which might run as high as 50 per cent of the cost of the program.

The Social Security Board, instead of the Bureau of Internal Revenue, would collect the taxes. The board would unquestionably play a dominant role in the management of the fund. Furthermore, although all the health funds of the country would presently or ultimately flow into this National Social Insurance Trust Fund and would constitute approximately one-fourth thereof, the W-M-D bill (S.1050) does not include on the board of trustees any representative of the health and medical professions. Despite assurances that the health funds would be protected, the fact remains that they would be controlled by laymen, and that the Surgeon General of the Public Health Service would have to go hat in hand to the chairman of the Social Security Board for approval of the contracts he would make with hospitals, doctors, and dentists. This bill would subordinate the health interests of the country to an agency—the Social Security Board—which has on its staff, so far as I know, not a a single licensed practitioner of medicine.

The bills are so drafted with respect to compulsory sickness insurance that the main administrative authority over the lives of all the people in this country would be subtly vested in the Social Security Board. Note the language of S.1606: The Surgeon General is authorized to draft the all-powerful rules and regulations for the compulsory sickness

insurance scheme, but he may not perform this, his most important administrative function, until he has consulted the Social Security Board and obtained the approval of the Federal Security Administrator. He must consult with the Social Security Board when he makes studies and recommendations concerning the provision of personal health services. He cannot make a move without consulting a lay board unskilled in medical matters and without obtaining the approval of the Federal Security Administrator who is not a physician.

These may seem like unimportant details until it is realized that they are the essence of control. The statutory provisions which have been deftly woven into the Wagner-Murray-Dingell bills relate particularly to (1) the control of the National Social Insurance Trust Fund, in which may some day be deposited upward of one-fourth the annual national income, and (2) the top policy-forming council—the so-called National Advisory Social Security Policy Council, which is appointed by the Social Security Board. This policy council is not limited in size and power as is the insignificant and wholly inadequate National Advisory Medical Policy Council which the Surgeon General is permitted to appoint. Although there is no statutory provision for inclusion among its members of any health or medical representatives, the Social Security Policy Council is authorized *inter alia* to make findings and recommendations on the "administration of medical, hospitalization, and related benefits." This extraordinary provision would permit determination of high policy in connection with the national health program by profes-

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sionally unqualified, non-medical advisers. I believe it to be an extremely dangerous provision.

The suggestion has frequently been made that amendments should be proposed to the sickness insurance title of the latest W-M-D bill and that the bill might thus be made acceptable. This is like asking a builder to remodel a Federal penitentiary into a California bungalow. One cannot have freedom within the framework of compulsory sickness insurance. It is political double-talk to speak of freedom and compulsion as conditions which may be enjoyed simultaneously. Perhaps the people of America wish to seek health under a scheme of nationalized medicine. But I doubt if that is the case. To the extent that they are sold on the idea they have been sold by promises that cannot be fulfilled.

The payroll tax proposed by W-M-D bill sponsors would be totally insufficient to finance the type of modern medical care that has been promised. We would not have the facilities or the health personnel even within ten years. It would take the full time of all the doctors in the country to spend as little as two hours a year on complete health examinations for everyone in the country. The gap between the promises in connection with W-M-D bills and the possible performance is indicative of a lack of candor on the part of Government experts who withhold from Congress and the public the facts which they have in their possession and which should be made public.

If the companion W-M-D bills were to be enacted, the only thing that would be sure to materialize would be the proceeds of the tax provisions. Whether or not the Government could deliver the health and medical services it promises, the National Social Insurance Trust Fund would bulge with new revenues. A bureaucracy with undreamed of power would be established. Every family would pay tribute to the Social Security Board for the support of the system of nationalized medicine, to say nothing of other parts of the national social insurance system for which there is considerable valid justification.

That such legislation would lead to the abolition of the private practice of medicine is freely admitted by the International Labour Office in a recent pamphlet in which this statement appears: "The fact is that once the whole employed population, wives and children included, is brought within the scope of compulsory sickness insurance, the great majority of doctors, dentists, nurses, and hospitals find themselves engaged in the insurance medical service, which squeezes out most of the private practice on the one hand, and and most of the medical care hitherto given by the public assistance authorities on the other. The *next step to a single national medical service is a short one* . . . " (Italics mine.)—MARJORIE SHEARON, PH.D.

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Medicine should match promotional work of socializers, Time's president believes

Once it was accepted as a fact in this country that "only the very poor and the very rich could enjoy proper medical care because only the very rich could afford to pay for it and the poor got it free."

The broad question before us now is how to insure the great middle-income group of this country—the country's wage-earners—of the best care when sickness comes to them and of the comfort of mind which results from their knowing they can afford to pay for it. It is not the problem of improving medical standards—the highest standards of medical practice in the world—but that of making them available to the people.

The problem has been pointed up in recent years by the politically inspired suggestion that it should be solved by state medicine. And so far, this solution unfortunately is the best advertised, most publicized one before the American people. But there *is* another solution. Those of us who have followed the really exciting development of voluntary prepaid insurance plans for hospital and medical protection believe that the voluntary method can be and will be the real solution.

That most people want prepaid health insurance there is now no question. Two polls of public opinion were recently taken on this subject. The first, made by the Opinion Research Corporation, showed that a great many people were opposed to governmental medicine. In fact, 76 per cent of the people questioned were opposed to governmental control of the medical profession, and 87 per cent thought that compulsory insurance would not provide a satisfactory solution to the problem of medical care costs. The second poll, taken by the highly reputable National Opinion Research Center at the University of Denver, indicated that 48 per cent of all the people questioned preferred Government compulsory insurance to voluntary prepaid plans—that 68 per cent thought the social security law should include Government medical insurance. But the findings of both polls proved conclusively that people do want some form of pre-

▶ Roy E. Larsen, president of Time, Inc., which publishes Time, Life, and Fortune, recently addressed the Philadelphia County Medical Association. This is a condensation of his remarks.

paid insurance, whether it be a compulsory or a voluntary plan.

During the war and in the ten years preceding it, the American wage-earners learned to look more and more to the Government for more and more things. The Government has brought him social security, maximum wages, minimum hours, and unemployment insurance. He is now being told by the Government that state medicine is essential to the continued health of himself and the Nation. Accustomed as he is by now to looking to the Government to solve national social problems, he perhaps regards this political medicine as a logical and necessary step. If the Government should, for instance, offer him a seemingly reasonable plan of compulsory medical insurance, he might accept it as a desirable Government action.

Seven years ago when Federal health insurance was first proposed in the Wagner bill, there was no answer to its sponsors' declaration that "voluntary plans just won't meet the need." At that time such a statement could not be refuted by history or statistics. The Blue Cross was just getting under way. Seven years ago there were only 1,500,000 people enrolled in the forty voluntary health insurance plans existent at that time. What has happened since is one of the most thrilling developments in this country and a great tribute to the men of medicine and to voluntary hospitals who have accomplished it. Think of being able to say of the Blue Cross plan, for example: "It has enrolled more people in less time than any voluntary program in the history of the world." In approximately ten years the Blue Cross hospitalization plan has enrolled more than 20,000,000 members; more than 3,000,000 people are now covered by private medical care insurance; another 11,000,000 are now protected by group policies in commercial companies, cooperative plans, and by other coverage.

This represents a total of well over 34,000,000 people now protected by voluntary health insurance.

But it has been in the last few years that the really exciting development has occurred. The State of Rhode Island early this year startled the Nation by reporting that 53 per cent of its population is now enrolled in the Blue Cross plan. At the same time Rhode Island announced a voluntary medical care plan, and first reports indicate that this new service has become a success and is on its way to top enrollment.

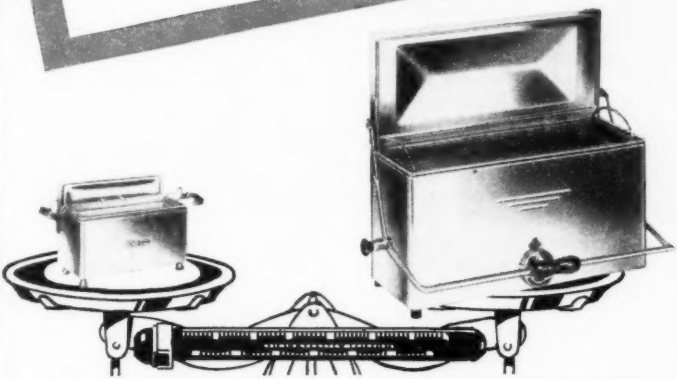
[*Continued on page* 142]

In Massachusetts a year ago, one of every six people was covered by private hospital insurance—this year, one in every three is enrolled. In the western part of Pennsylvania, enrollment in the Blue Cross plan in recent weeks has been terrific, to say the least. On January 1, 1946, 851,245 people were enrolled in the Hospital Service Association of Pittsburgh. Only four months later, total enrollment in this plan was just short of one million—a gain of almost 150,000. That is at the rate of a 54 per cent increase in a year.

Such records challenge Senator Murray's statement that "voluntary plans just won't meet the need." But they do not yet refute it, and exciting as the recent progress of the voluntary health plans has been, we still cannot dodge the fact that only one man or woman in seven is protected by them. Six-sevenths of the nation is still without any kind of prepaid hospital or medical insurance protection. Further, management realizes, as do the doctors, that there are still formidable "bugs" in the machinery of voluntary prepaid medical insurance. The difference between the voluntary insurance plans in the different states often makes it difficult for the business man operating branches on a national scale to secure the same over-all protection for his workers. In some sections, one or more of those services may be lacking. Coordination on a nation-wide basis of these voluntary plans is still uncompleted, yet planning is under way to smooth out such "bugs" and to present a unified front of an over-all medical insurance plan to the general public.

It is my personal belief—based on the record of those states and communities which have really done a

They Balance ...Despite Size



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job of selling their voluntary insurance plans—that 80 million people can be reached and covered by them. Take 55 million employes—or Mr. Wallace's 60 million—and add their families. You then have a potential for voluntary health insurance plans in excess of 80 millions of people. With such an enrollment, there could be no argument for state or Federal health insurance.

But even the fine record to date of the voluntary plans is not well enough known to enough people. The time has come, the ammunition is now available, for concerted action on the part of the medical profession and business leaders to spread the news of the rapid growth and the successful operation of these voluntary plans. It is the *best* immediate answer to the bills which are being introduced, not only in Congress, but in the states as well.

I, for one, would like to see more publicity put out by doctors and voluntary insurance plans to spread the available information concerning their achievements to every corner of the land. I have the courage to suggest this break with traditional ethics in the medical field because, in western Pennsylvania and in Massachusetts, for example, the job of informing the public *is being done through paid advertising* in the daily newspapers, on car cards, and over the radio with the greatest of success. This radical step in Massachusetts, taken in the citadel of conservative and traditional medicine, was approved by the Massachusetts Medical Society—the oldest in the country. I can understand that it was not an easy decision for the medical profession to make, but now that we know that advertising of voluntary prepaid medical plans has been successful wherever it has been tried and that, therefore, it is in the interest of the potential members of the plans and of the communities at large, I hope that it will be adopted by voluntary plans throughout the country.

I do not need to dwell on the danger to the standards of medicine and to the free enterprise system inherent in a politically sponsored program of state medicine. Yet, since it is news and significant because of its recent adoption, the case of state medicine in New Zealand may be of interest to you. There, in what has been called the "laboratory of socialism," in a land which has more widespread security legislation and more economic controls than any other democratic country, state medicine was adopted in 1941. Within four years—by October 5, 1945, to be exact—The New York Times was headlining a story on the progress of this development as follows: "Medical Rackets Grip New Zealand." And the conservative Christian Science Monitor stated in its report: "The New Zealand system of tax-financed, free medical care has resulted in the debasing of medical practice in this country, vast increases in physicians' earn-

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Supplied in 15-cc. and 50-cc. bottles with special dropper calibrated for 0.3 cc. (infant) and 0.6 cc. (older child) doses.

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ings, and a decline in their value to the community." And recently New Zealand's Health Minister, Arthur Nordmeyer, announced in the House of Representatives that, because of widespread abuses, his Government was seriously considering whether free physicians' service would be continued. The New Zealand National Medical Council has revealed some of the details of the debasing and prostituting of the medical service in that country. To mention a few, they report that there has been over-consultation, the speedy examination of patients —some at rates of twelve an hour— payment of $6,000 to a doctor for one afternoon's work, and the charging of a fee for each patient seen on visits to institutions for the aged and invalid. It is charged that, out of every 100 patients who consult a physician in New Zealand today, only twenty-five are able to benefit from his advice. The medical superintendent of New Zealand's largest hospital says: "The politicians of both parties have gone far to foul the name of the profession to which I have the dishonor to belong. For us upon our last professional lap it does not matter much, but what of our young doctors?"

But we don't have to look as far as New Zealand to see the shocking effects political favor or lack of it can produce when the state enters the medical field. When General Hawley returned from the European theater to become medical chief of the Veterans Administration, he found Veterans Administration hospitals overcrowded, understaffed, and mired in politics. Said Dr. Hawley: "It was a mighty sick thing we took over, and there aren't going to be any miracles." Generals Bradley and Hawley are doing a fine job today in trying to rehabilitate the veterans' hospitals system.

To the doctors who are attempting to provide prepaid medical insurance plans, all those who are interested in the preservation of the high standards of medical care in this country and in the free enterprise system owe a great debt of gratitude. Now they need our help —the helping hand of American business management in extending these services to the wage earners and their families who need them. We have an opportunity to prove beyond the shadow of a doubt the fact that the greatest social measures can be and will be initiated and effected by the people themselves without reliance upon socialized public economics. —ROY E. LARSEN

to combat

the depression of

chronic organic disease Many patients with chronic organic disease —arthritis or asthma, for example—sink into a persistent depression characterized by discouragement, or even despair. Unless effectively combated, this depression may handicap management of the basic disorder and intensify its symptoms.

By restoring optimism and interest in useful living, Benzedrine Sulfate frequently helps to overcome prolonged depression accompanying chronic illness. Obviously, in such cases, careful observation of the patient is desirable; and the physician will distinguish between the casual case of low spirits and a true mental depression.

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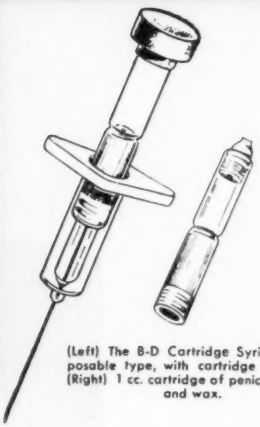
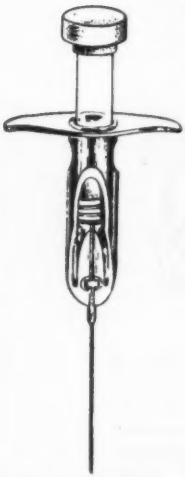
Easier Administration of Penicillin in Oil and Wax



(Left) The B-D Cartridge Syringe, d
posable type, with cartridge insert
(Right) 1 cc. cartridge of penicillin in
and wax.



The B-D Metal Cartridge Syringe with cartridge inserted

Bristol Laboratories now introduce two techniques whic
are designed to make the administration of penicillin easi
and more practical. Both of them make use of a 1 cc. gla
cartridge of Penicillin in Oil and Wax. A completely ne
feature of the Bristol Cartridge is a specially designe
rubber stopper which permits an aspirating test to preve
venoclysis.

Bristol Cartridges may be used anywhere, any time wit
the B-D Cartridge Syringe, Disposable Type. (Above) Fo
office or hospital, many physicians will prefer the B-
Metal Cartridge Syringe. (Left)

In addition to the 1 cc. cartridges, Bristol Penicillin i
Oil and Wax is still available in 10 cc. rubber-stoppere
vials, for those who prefer to employ a luer-lock syringe. A
forms are available through your regular source of supp

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The Newsvane

Medical School Head Says Bias Prompts Charges

The Essex College of Medicine and Surgery, New Jersey's only medical school, became the center of a bitter controversy last month when the State Board of Medical Examiners asked Dr. Adolph M. Koch, president of Essex College, to show cause why its license should not be revoked.

Dr. Koch, who opened the college in Oct. 1944, charged that the revocation move was instigated by his opponents on the college board under the leadership of Dr. Clarence R. O'Crowley, former board chairman, who wanted to oust him because of his refusal to institute a quota system for religious and racial minorities.

Included among the college's 105 students are Catholics, Protestants, Jews, Negroes, Italians, Puerto Ricans, South Americans, and a Chinese.

Both Dr. O'Crowley and Dr. Earl S. Hallinger, secretary of the state medical board, denied any desire to establish a quota system at Essex. The state board, in asking that the college's license be revoked, charged that the college lacks adequate financial support; that it does not provide suitable study facilities; that students without necessary pre-medical scholastic credits are admitted; and that the college has fraudulently exaggerated its financial assets.

5,707 *New Physicians Licensed in* 1945

The U.S. got 5,707 new physicians last year, says the AMA Council on Medical Education and Hospitals. However, 3,815 U.S. physicians died in the same period, making the real gain 1,892.

Despite the general increase, there were pronounced decreases in the number of physicians registered in Georgia, Kansas, Kentucky, Maryland, Michigan, Missouri, Mississippi, Nebraska, Ohio, Pennsylvania, and Virginia. Increases were most noticeable in Arkansas, California, the District of Columbia, Florida, Illinois, Iowa, New Jersey, and Indiana.

Island Doctor's Death Costs Baby's Life

Within a few hours of the death of their only physician, the 700 inhabitants of tiny Smith Island in Chesapeake Bay were shaken by a second tragedy: the death of a six months' old baby who succumbed in his father's arms before he could be transferred to the Maryland mainland. The deceased physician, Dr. William F. Seabold, had been

serving the island's fishing families under a locally developed socialized-medicine scheme, whereby each of the families pays $1.50 a month to a medical board. The latter hires a doctor on a salaried basis and furnishes him with combined office and living quarters on the island.

Viennese Paying $1.50 for Single Aspirin Tablet

Although aspirin, cold tablets, sodium bicarbonate, and some other mass-produced items are being shipped to Europe in fantastic quantities by UNRRA and other relief agencies, the demand is so great that people in Vienna are paying as much as $1.50 for a single aspirin tablet, according to the Office of Pharmacal Information.

Russia alone has received 5,000 pounds of aspirin, 40,000 pounds of vaseline, and half a million cold tablets, this source reports.

Survey Shows Rise in Education Costs

Tuition and dormitory fees in the undergraduate and professional schools of the United States are being raised from 15 to 50 per cent, a survey of representative institutions revealed recently.

The tuition fee in medicine and dentistry at Columbia College has been raised from $250 to $300 per session. Other typical increases are those at Yale, which has raised its undergraduate tuition fees from $225 to $250 a term, and at Princeton, where fees have been raised from $450 to $500 a year.

Among the reasons advanced for fee increases by the colleges are their higher textbook costs, higher salaries, and the general increase in operating expenses resulting from inflation.

Service M.D.'s Refusing Reserve Commissions

Few medical officers are responding to appeals made to them at Army separation centers to accept reserve commissions, it is reported. Refusal to accept reserve status is apparently a reflection of widespread discontent among M.D.'s over treatment they received in the armed forces.

Informal polls of opinion among service and ex-service doctors have

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Milk may be made into easily digested rennet-custards with either "Junket" Rennet Powder or Tablets.

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indicated that many felt too much of their time was wasted in non-professional duties; that they resented regimentation; that they found promotion policies unfair; and that, by comparison with some other officer groups, they believed they were underrated and underpaid.

Form Council to Fight Heart Disease

Led by Gov. Thomas E. Dewey of New York, a combination of prominent laymen and physicians have formed the Council for Heart Disease, to stimulate research and public education in heart and cardiovascular diseases. The council, whose members include Dr. Edwin P. Maynard Jr., president of the New York Heart Association, and Dr. A. Wilbur Duryee, the Governor's physician, plans to raise a half million dollars next year for research and care of the sick.

The council will raise funds by subscription, centering its activities in New York in the beginning and then spreading across the country.

Cultist Is Accused of Causing Blindness

Alleging that she was partially blinded for life and is now unemployable as the result of therapy suggested by a Yoga consultant, a young widow has brought suit in the New York courts. She charges that the consultant, an ex-actress, recommended gazing at the midday sun for an hour, claiming that its rays would have a healing effect. According to a sociologist who

investigated the case while making a study of cultism, the widow was merely suffering from emotional fatigue when she consulted the Yoga practitioner.

Psychoanalytic Tests Urged for Leaders

Labor leaders, business executives, and public officials should be subjected to psychoanalytic tests to determine their temperamental fitness for leadership, says Prof. Harold D. Lasswell of the Yale University Law School.

It is Professor Laswell's belief, expressed before a recent meeting of members and patrons of the Association for the Advancement of Psychoanalysis, that psychoanalysts hold a "refined scientific instrument for answering the question of who can be trusted with power."

He thinks that such tests could eliminate from places of influence persons given to impatience, malice, and anger. Exactly how people could be made to abide by the conclusions of the tests, Professor Lasswell doesn't say.

Altmeyer Chides Doctors on W-M-D Bill Stand

The medical profession's opposition to President Truman's health program, which includes the Wagner-Murray-Dingell bill, is unreasonable, Arthur J. Altmeyer, chairman of the Social Security Board, told the 1946 annual meeting of the National Conference of Social Work. [*Continued on page* 158]

Something New is Coming...

...for the Relief of Allergies

● An announcement will soon be made regarding a new Ciba product. It will be of such wide application that every physician will want to be informed.

CIBA

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You Can Clear Up Stubborn Cases of Acne

Here is a new remedy for acne vulgaris.

Intraderm Sulfur Solution combines the new skin penetrating principle with a traditional medication.

The treatment is simple, effective, rational.

Clinical work to date indicates that nearly all cases can be cleared up or brought under control. The physician, of course, must supervise his cases and prescribe the frequency of application and duration of use of the new method.

If you have obtained disappointing results with the methods you have employed to treat acne, you are invited to make a clinical test with Intraderm Sulfur. It was developed specifically for the treatment of acne vulgaris.

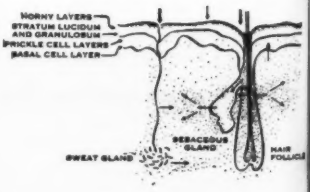
It contains sulfur in its most effective form—soluble, highly-active polysulfide in a mildly-alkaline, skin-penetrating base.

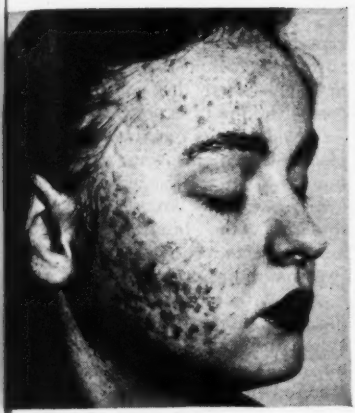
Intraderm Sulfur is applied to affected areas as often as tolerated, usually once or twice daily until healing is complete.

WELL TOLERATED—REQUIRES NO DRESSING

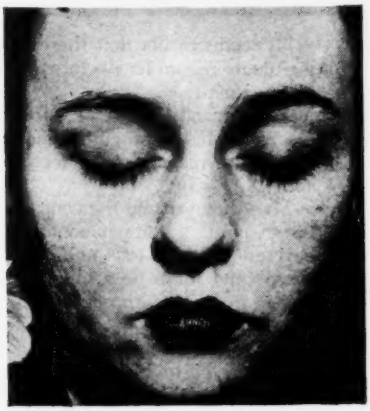
HOW INTRADERM PRINCIPLE WORKS

Intraderm solutions penetrate the intact human skin through the hair follicles and sebaceous glands and to a lesser degree through the sweat glands. The routes are shown by the arrows in the diagram at the right. By this new biophysical action, medications can *act at the site* of the infection.





Acne pustulosa, duration 7 years. Previous treatment: 20 X-rays, carbon dioxide snow, sulfur salves.



Picture after 28 weeks of treatment with Intraderm Sulfur.

BACKED BY 5 YEARS OF CLINICAL RESEARCH

Intraderm Sulfur for the local treatment of acne is offered to physicians after 5 years of clinical research.

Carefully controlled experimental and clinical studies having established the effectiveness of the basic Intraderm Solution as a skin-saturating agent, therapeutic trials with Intraderm Sulfur Solution were begun.

One of the groups studied consisted of a total of 130 of the most stubborn cases of acne comedo, papulosa, pustulosa, indurata, cystica and erythematosa. Most had been resistant to treatment with other local remedies, but responded promptly to Intraderm Sulfur, so that the results compared favorably with X-ray treatment. (*MacKee, Wachtel, Karp and Herrmann, Journal of Investigative Dermatology, Oct., 1945.*)

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Limited to Medical Profession in U. S. A.

"It seems to me that there is no legitimate reason for doctors to protest against any system that would leave the conditions of practice unchanged while arranging a method for the payment of their fees," he said.

Mr. Altmeyer told the conference the voluntary prepayment plans covered "only a few million persons," and that these plans had "failed to insure those who most need this protection." He asserted that "consumers as well as doctors have a right to be heard, and to participate actively in the planning for medical care," and that "consumers do not have these rights in the plans being organized and sponsored by medical societies."

M.D. Says Profession Is Deteriorating

Recent trends in medical practice are breaking down the value and prestige of the medical profession, says an anonymous physician in a featured article in This Week, a magazine distributed throughout the country by the New York Herald Tribune.

"The plain truth is that doctors are losing the human touch," he says. Overspecialization is "narrowing the general practitioner's role to that of a transmission belt to the specialist's office," and giving rise to a host of gall-bladder specialists, throat men, and allergy experts who are "incapable of diagnosing the whole man." He warns that too often the specialist becomes "a kind of expert repairman"—a jeweler "who oils the watch, replaces the mainspring, and fixes the stem without ever knowing the owner." If this trend, which is squeezing the humanity out of medical practice, persists, he says, "we shall approach mechanical perfection without the sense to make the best use of our discoveries. When and if that happens, the doctor will find himself losing his honored place in society."

The anonymous writer suggests, as a partial solution, that "liberal arts courses, which are today snowed under by the 'ologies,' be restored" to medical education, because "culture and character, as well as skill with a hypodermic needle, are necessary to create a doctor."

He suggests also that steps be taken to "weed out incompetents," and to continue the education of physicians after they have begun to practice. He says that the need for this is especially urgent among doctors whose medical skills fell into disuse while in the armed forces, and among those new physicians who were rushed through "highly compressed, five-year nightmare" wartime courses and "shortened interneships."

Urging group practice as an important part of the solution to the new problems of medical practice

he says: "It is my belief that we should cease working as monopolistic individuals, and work instead cooperatively. In place of assemblyline specialization, let us have more of the group practice which has worked out so well in rural health centers."

Prepayment Plan Started by Illinois Doctors

After a one-year "test run" in the Rockford, Ill., area, the Illinois State Medical Society has launched a voluntary prepayment plan covering medical, surgical, and obstetrical care in the home and hospital.

The plan, which is to be operated by the North American Accident Insurance Company of Chicago, does not cover hospital costs. It provides for cash indemnity payments to insured patients who are to pay their doctors directly.

Dr. Everett P. Coleman, president of the medical society, said in announcing the plan that premiums would be $1 a month for men, $1.50 a month for women, and $1 a month for dependent children who are more than three months and less than eighteen years old. There is also a family group rate of $3.25 a month.

Indemnities range from $5 a month to $100, depending on the nature of treatment required. In sickness cases, payments begin with the third visit to the doctor, but in injury cases they begin with the first.

Contrasting his state society's plan with compulsory health insurance proposals, Dr. Coleman observed: "If the Wagner-Murray-Dingell bill should succeed, it would inevitably lead to medical stagnation. This policy leaves the patient free to select his own physician and to manage his own affairs without the expensive bungling interference of bureaucrats."

Medical Officers Entering Psychiatric Field

The present acute shortage of efficient psychiatric care for both civilians and ex-servicemen will be relieved somewhat by the entrance of numerous Army and Navy medical officers into the psychiatric

RESERVOIRS

The reservoir behind Boulder Dam changes barren earth to lush, verdant fields. It re-creates life; and the effects from the fountain-head flow a long, long way.

Comparatively insignificant in size, but important to its possessor, the human gallbladder, too, is a reservoir. Interference with resorption of the bile by the gallbladder walls leads, as the doctor so well knows, to stasis, one of the commonest causes of general ill health.

Doxychol-K

The overall purpose of the bile is generally assumed to be its action in the digestion of fats; and the bile constituent to which this action is especially attributed is desoxycholic acid. Desoxycholic acid is an important part of Doxychol-K Tablets. Another is Ketocholanic acids which provide 90% dehydrocholic acid, the most effective hydrocholeretic of the bile acids.

Doxychol-K is indeed a reservoir of bile acid wealth. The tablets are supplied in bottles of 100, 500, and 1000.

George A **Breon** & Company

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BREON

field, Dr. Forrest M. Harrison, director of the Psychiatric Personnel Placement Service, has reported to the National Committee for Mental Hygiene.

Dr. Harrison, formerly chief of psychiatry in the U.S. Navy, says that since last December, when his service began operation, more than 650 medical officers have applied. About 35 per cent of these went directly into psychiatric positions, and the remainder requested further training.

A huge number of training and work openings for psychiatrists exists in state mental hospitals, Dr. Harrison says. But he believes that states must make a "determined effort to make their institutions more attractive to younger physicians if they hope to fill the vacancies and provide adequate treatment for the patients under their care."

AMA Drug Council Revamps Rules

The AMA Council on Pharmacy and Chemistry has announced revisions in its Rules for the Acceptance of Proprietary Articles which have remained practically unaltered for more than forty years.

The new version of the rules revises or rescinds provisions rendered superfluous by the Federal Food, Drug, and Cosmetics Act which now makes compliance with certain of the council's early regulations legally enforceable.

The new version also has acknowledged that the council has failed in its attempt to prevent a single drug from being marketed under various "aliases." It now permits use of multiple names on con-

dition that the manufacturer feature the "unprotected" name of his product equally with his brand name.

As a third change, the council has liberalized its policy toward "advertising to the public." It will now countenance such advertising when it feels that the benefits derived exceed the possible dangers.

FTC Issues Artificial Limb Regulations

To "safeguard" 600,000 users of artificial limbs in this country, of whom 16,000 are veterans, the Federal Trade Commission has issued a stern six-point directive to some 300 prosthetics manufacturers. The directive, probably a consequence of complaints lodged against some manufacturers by dis abled veterans, bans the followin practices:

1. Deceiving a purchaser as t the design, weight, strength, safety or any other characteristic of product, or claiming that an arti ficial limb can be just as satisfac tory as a human limb.

2. Failing to disclose any defec in the product or to explain tha benefits depend on the area an type of the amputation.

3. Guaranteeing a fit when th guarantee cannot be sustained.

4. Sponsoring a misleading dem onstration.

5. Publishing false testimonial by artificial-limb wearers.

6. Using the terms "tailored" o "custom-made" when they have n basis in fact.

Non-compliance with the direc

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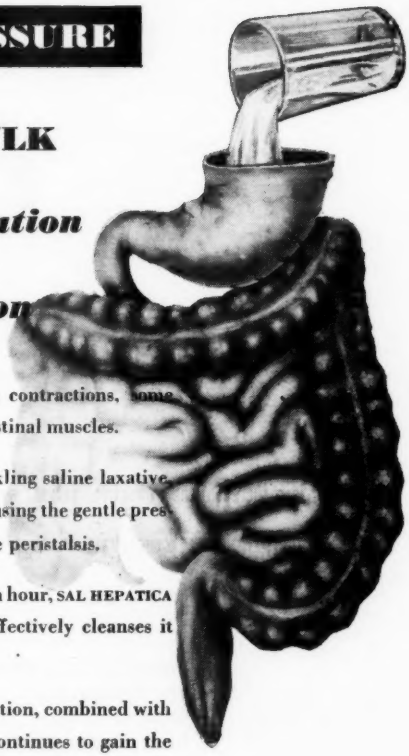
relieves constipation

without irritation



In order to reinforce peristaltic contractions, some laxatives act by irritating the intestinal muscles.

In contrast, SAL HEPATICA, a sparkling saline laxative, follows nature's own methods by using the gentle pressure of "liquid bulk" to stimulate peristalsis.

Acting promptly, usually within an hour, SAL HEPATICA flushes the intestinal tract and effectively cleanses it of waste.

Because of this quick yet gentle action, combined with its pleasant taste, SAL HEPATICA continues to gain the ever-increasing confidence of your profession.

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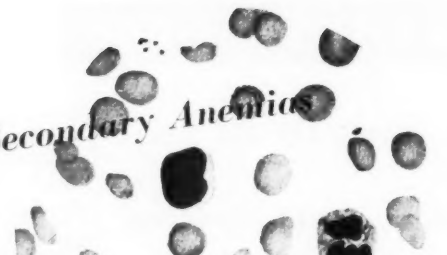

Campobiol is a therapeutically effective, potent, well tolerated combination of vitamin B complex factors with liver concentrate and iron. Marketed in easy-to-swallow gelatin capsules, with a pleasing aromatic odor.

EACH CAPSULE CONTAINS

Thiamine hydrochloride (vitamin B_1)	2 mg.
Riboflavin (vitamin B_2)	2 mg.
Nicotinamide	10 mg.
Ferrous sulfate (anhydrous)	100 mg.
Liver concentrate (1 to 20)	200 mg.

Prophylactic dose for adults: 1 capsule daily. Therapeutic dose for adults: 2 or 3 capsules three or more times daily, depending on severity of the anemia.

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Brand of
Vitamin B COMPLEX Factors
with LIVER Concentrate and IRON

SUPPLIED IN BOTTLES OF 50 AND 200 CAPSULES

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ive makes a company liable to prosecution for "unfair methods of competition."

ADA Against S.1606; Asks Grants-in-Aid System

The American Dental Association is opposed to the Wagner-Murray-Dingell bill, the Senate Committee on Education and Labor was told last month by Dr. Carl O. Flagstad, chairman of the ADA's legislative committee. The association, he said, believes that a compulsory health insurance system, basically similar to those in effect in foreign countries, should not be established in the U.S. without incontrovertible proof that the errors of the foreign systems will not be perpetuated over here. Pointing out that the grants-in-aid system has been effective in meeting certain health deficiencies, Dr. Flagstad declared the ADA would like to see the system enlarged to meet all such needs. The association, he added, "believes that the right of a state to determine the methods of meeting its health needs should not be taken away" and that "a program as comprehensive as the one proposed should not be designed without seeking the official cooperation of all agencies and professions involved."

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